DISTRICT COURT, DENVER COUNTY, STATE OF COLORADO Address: 1437 Bannock Street, Denver, CO 80202	

ROBERT PHILIPPE; **MICHAEL PITCOCK and HARRILYN PITCOCK;** **RENAE STEINBECH;** **JULIE SCHULTZ DUFF;** **KATE FIELDS and DALE FIELDS;** **SANDRA DOHALLOW and JAMES NEIL;** **SHAWN HAND;** **KEVIN DICKES;** **JACQUELINE ARMSTRONG and JOSEPH ARMSTRONG;** **DENNIS GROVEN and SHELLY GROVEN;** **RICHARD STOTLER;** **SARAH CLINE-LEBSACK and DAVID LEBSACK;** **TAMMIE WELCH;** **DEBBIE SCHULZE and JON SCHULZE;** **ANGILA LEWANDOWSKI;** **CAROL MURPHY;** **KACEY CRAIG and JESSE CRAIG;** **BRETT SIEGRIST;** **RICHARD KNIPPELMEYER and CONNIE KNIPPELMEYER;** **MOHAMED ALI ELMI;** **KIM KANE;** **LAUREN MORALES;** **RAELENE MIDDLESTADT;** **KAREN LUND and ROBERT LUND;** **KATHRYN HANSON and JAMES HANSON;** **KEVIN ALLEY;** **JERRY OWEN;** **JONATHAN COLBETH;** **MICHELLE COLEMAN;** **CARMELITA CARRILLO;** **BETTY WRISTON and THE ESTATE OF THOMAS WRISTON;** **MARY GOYETTE;** **ANTHONY MARINO;** **LUANA KURZ;** **JOANNE STEWART;** **REBECCA BROWN;** **JEANNE MEARDON;** **BRETT MARTINEZ;** **KENNETH LUTZ;** **JANELLE FAVUZZA;** **LISA EDELEN;**	**▲COURT USE ONLY ▲**

MARY DYER; **NICHOLAS BAKARICH and DEBORAH BAKARICH;** **MARY ROBINSON;** **GARY ESCH;** **LEANNE PRIDAY;** **WILLIAM SUAREZ;** **TREVOR WILLIAMSON and LORI WILLIAMSON;** **DARBY FISH;** **MICHAEL GIBSON;** **GORDON HALL;** **NINA TISDALL HAWKINS;** **CHAD MEYERS;** **GINNY PEIRCE-ANSTINE;** **PERRY SKINNER;** **RUTH SCHWARTZ;** **CHARLES MORGANTI and MARSHA MORGANTI;** **JIM TAYLOR and SALLY TAYLOR;** **KAREN WILSON;** **MARK and ILENE REINHART;** **THERESA BRAZULIS and JEFFREY BRAZULIS;** **JOHN LOVETT and CLARE LOVETT;** **JONATHAN KRASOWSKI and CYNTHIA ERICKSON;** **SANDY JOHANSEN;** **LORI BROWN;** **DON RASBERRY; and,** **JANET PETTERSEN and ERIC PETTERSEN** Plaintiffs v. **CENTURA HEALTH CORPORATION; PORTERCARE ADVENTIST HEALTH SYSTEM d/b/a CENTURA HEALTH-PORTER ADVENTIST HOSPITAL; and, PORTER ADVENTIST HOSPITAL** Defendants	

Attorneys for Plaintiffs David S. Woodruff, #32585 Megan K. Matthews, #43998 ***WAHLBERG, WOODRUFF, NIMMO & SLOANE LLP*** 4601 DTC Parkway, Suite 950 Denver, CO 80237 Phone Number: 303-571-5302 Fax Number: 303-571-1806 E-mail: david@denvertriallawyers.com megan@denvertriallawyers.com	Case Number: 2019CV032224 Div:
FIRST AMENDED COMPLAINT AND JURY DEMAND	

Plaintiffs listed in the caption above, by and through their attorneys, David S. Woodruff and Megan K. Matthews of the law firm Wahlberg, Woodruff, Nimmo & Sloane LLP, respectfully file this First Amended Complaint and Jury Demand and alleges as follows:

I. PARTIES AND JURISDICTION

1. Plaintiffs who had surgeries and subsequently developed surgical site infections ("Plaintiffs") are and were at all relevant times herein citizens of Colorado, with the exception of the following Plaintiffs:

   a. Plaintiff John Krasowski was a citizen of Colorado at the time of his surgery on April 4, 2018 but now resides in the city of Morris, Grundy County, Illinois.

   b. Plaintiff Michael Pitcock was a citizen of Colorado at the time of his surgery and subsequent development of his surgical site infection but, now resides in the city of Kerrville, in the county of Kerr, Texas.

2. Numerous Plaintiffs were, at all times relevant herein, married to their spouses ("Plaintiffs' Spouses"), who are also plaintiffs to this action for purposes of loss of consortium claim, as is discussed in more detail below.

3. Plaintiffs' Spouses are and were at all times relevant herein citizens of Colorado, with the exception of following Plaintiffs' Spouses:

   a. Plaintiff Spouse Claire Lovett was a citizen of Colorado at the time of her husband's surgery on April 4, 2018 but now resides in the city of Morris, Grundy County, Illinois.

b. Plaintiff Spouse Harrilyn Pitcock was a citizen of Colorado at the time of her husband's surgery and subsequent development of his surgical site infection but, now resides in the city of Kerrville, in the county of Kerr, Texas.

4. Defendant Centura Health Corporation is a Colorado corporation with its principal place of business located at 9100 E. Mineral Circle, Centennial CO 80112.

5. Defendant Portercare Adventist Health System, d/b/a Centura Health-Porter Adventist Hospital, is a Colorado corporation with its principal place of business located at 9100 E. Mineral Circle, Centennial, CO 80112, and is in a joint operating agreement with Catholic Health Initiatives in ownership of Defendant Centura Health Corporation.

6. Defendant Porter Adventist Hospital, d/b/a Centura Health-Porter Adventist Hospital, is a Colorado non-profit corporation with its principal place of business located at 2525 S. Downing Street, Denver, Colorado 80210, and is owned by Defendant Portercare Adventist Health System and operated by Defendant Centura Health Corporation.

7. Together and jointly, Defendant Centura Health Corporation and Defendant Portercare Adventist Health System own and operate Centura Health-Porter Adventist Hospital, known to the consumer public as "Porter Adventist Hospital", located at 2525 South Downing Street, Denver, Colorado, 80210 in the City and County of Denver, Colorado.

8. The corporate defendants named herein are jointly and severally liable for the negligent acts alleged herein, in that such acts were committed at Porter Adventist Hospital, which is owned and operated by Portercare Adventist Health System and Centura Health Corporation. The negligent acts and omissions alleged herein were committed and ratified by all Defendants. As such, and for purposes of simplicity and clarity, the defendant corporations shall be collectively referred to herein as "Defendant Porter."

9. Defendant Porter includes, but is not limited to, the governing body, leadership, chief executive officer, other executive officers, board members, and/or trustees of Defendant Porter Adventist Hospital, Defendant Porter Adventist Health System, and Defendant Centura Health Corporation.

10. All three named Defendants are citizens of Colorado and nearly all Plaintiffs are Colorado residents, such that complete diversity does not exist.

11. This Court has personal and subject matter jurisdiction over this matter pursuant to C.R.S. § 13-1-124(1)(a), (b), and (c).

12. Venue is proper in the City and County of Denver pursuant to C.R.C.P. 98(c) because Porter Adventist Hospital resides and transacts business in the City and County of Denver, and because the negligent acts and/or omissions alleged herein and giving rise to this action occurred in the City and County of Denver.

II. INTRODUCTION

13. Plaintiffs incorporate the previous paragraphs by reference as set forth herein.

14. This lawsuit is premised upon allegations of corporate negligence by Defendant Porter and its leadership and staff, resulting in systemic and ongoing infection control breaches at Porter Adventist Hospital from mid-2015 through late 2018.

15. During this time frame, and as set forth in more detail below, Defendant Porter and its leadership and staff failed to use reasonable care to ensure proper cleaning and sterilization of surgical instruments, equipment and environment as required by hospital protocols, state and federal law, and industry Standards of Practice; failed to use reasonable care in tracking and correcting deficiencies resulting in known contamination of surgical instruments; failed to use reasonable care in monitoring and responding to Surgical Site Infections (SSIs) and blood-borne infections; knowingly failed to comply with state and federal laws regarding reporting of infections and adverse events; and, knowingly concealed these ongoing and systemic problems from regulatory authorities, patients, and medical staff.

16. As a result of such corporate misconduct, Porter Adventist Hospital suffered systemic failures in cleaning and sterilizing surgical instruments from early-2015 through and including late 2018.

17. The aforesaid negligence of the Defendants directly and proximately caused hundreds of severe infections in surgical patients from early-2015 through late 2018, including severe surgical site infections in the named Plaintiffs herein.

18. Plaintiffs underwent surgeries at Porter Adventist Hospital on various dates between January of 2015 and the end of 2018. During these surgeries, surgical instruments were used which had been improperly sterilized by the Sterile Processing Department (SPD) at Porter Adventist Hospital. As a result, Plaintiffs developed severe infections in their surgical sites or other blood-borne infections, requiring, *inter alia*, additional hospitalizations for medical complications, surgeries and other procedures, intravenous antibiotics, and causing Plaintiffs to suffer associated economic and noneconomic damages, and also causing Plaintiffs' Spouses to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

III. FACTUAL ALLEGATIONS RELATED TO DEFENDANT PORTER'S ACTIONS

The Importance of Sterilization in the Hospital Setting

19. Surgical asepsis—the absence of infectious material or microorganisms within invasive procedures—is a fundamental requirement of all operative or other invasive procedures.

20. Hospitals that offer surgical services, including Defendant Porter, have a duty to ensure surgical asepsis, including establishing and enforcing standards for sterile technique, and to follow all laws, protocols, and industry Standards of Practice.

21. A fundamental aspect of surgical asepsis and sterile technique is the use of sterile equipment and instruments in all invasive procedures, including surgeries.

22. Hospitals that offer surgical services, including Defendant Porter, have a duty to ensure surgical asepsis by properly sterilizing surgical instruments and equipment in compliance with hospital protocols and industry standards.

23. Failure to properly clean, inspect, disinfect, or sterilize surgical instruments and equipment is known to cause transmission of pathogenic microorganisms from a contaminated device and create a risk for patient injury, including a surgical site infection (SSI).

Porter Adventist Hospital's Sterile Processing Department

24. At all relevant times, Defendant Porter provided, to its patients and for use by its surgical staff, surgical instruments and equipment for surgical services performed in the operating rooms at Porter Adventist Hospital.

25. At all relevant times, Defendant Porter operated a "Sterile Processing Department" (SPD) for the purpose of cleaning, decontaminating, and sterilizing surgical instruments and equipment.

26. At all relevant times, Defendant Porter employed the staff that was directly responsible for cleaning, decontaminating, and sterilizing operative environments and surgical instruments.

27. At all relevant times, surgical instruments were to be initially cleaned prior to leaving the operating room ("OR"), as required by hospital protocol and industry safety standards.

28. Surgical instruments were then to be processed and sterilized by Porter Adventist Hospital's "Sterile Processing Department" ("SPD"), including, but not limited to, decontamination, prep and pack, sterilization, and dispatch, as required by hospital protocols and industry safety standards.

29. The primary purpose of the Sterile Processing Department was to ensure that surgical teams and staff had clean, sterile surgical instruments, transported and delivered in a timely and sterile manner, so as to ensure surgical asepsis.

30. The staff, employees and/or agents at Defendant Porter who were responsible for cleaning, decontaminating, and sterilizing operative environments and surgical instruments were, at all relevant times, acting in the course and scope of their employment with Defendant Porter.

31. Alternatively, at all relevant times, Porter Adventist Hospital staff were acting within their actual and/or apparent authority as agents of Defendant Porter.

The Joint Commission and Colorado Department of Health Investigations Reveal Extensive Violations of Sterile Procedure

32. In late 2017 and/or early 2018 the Joint Commission began receiving complaints regarding contaminated instruments at Defendant Porter.

33. In response to complaints received regarding contaminated instruments, first the Joint Commission, and then the Colorado Department of Public Health & Environment ("CDPHE") and the Centers for Medicare & Medicaid Services ("CMS"), conducted on-site investigations and surveys (hereinafter "Surveys") which were completed in February and April 2018.

34. The 2018 investigations by The Joint Commission ("TJC"), CMS, and CDPHE uncovered evidence that Porter Adventist Hospital had ongoing problems and failures with sterilization of surgical equipment and/or instruments.

35. The 2018 investigations by The Joint Commission ("TJC"), CMS, and CDPHE also uncovered evidence that such sterilization failures at Porter had been ongoing for at least "several years."

36. On February 20, 2018, a Joint Commission Survey of Defendant Porter declared an "Immediate Threat to Health and Safety" due to infection control breaches in the sterilization process.

37. An Immediate Threat to Health and Safety determination cannot be disputed, and requires immediate action from the organization affected.

38. Of the approximately 21,000 healthcare facilities (not just hospitals) served by the Joint Commission, only 13 were deemed to be an Immediate Threat to Health and Safety in 2013.

39. The Joint Commission's initial on-site survey noted:

> "[I]n the most recent 13-month time period there were 129 occurrences of incomplete removal of gross surgical contamination as required by the AAMI guidelines followed by the surgical department. This was evidenced by visible bioburden such as bone, hair, or tissue, identified on instruments that had completed the steam sterilization process."

40. The CDPHE in its Survey noted "a complete lack of pre-cleaning of surgical tools among ortho/neuro/spine cases at the point of use through staff interviews."

41. During their investigations, The Joint Commission, CMS, and/or CDPHE observed direct violations of sterile protocol and direct violations of hospital protocols and industry Standards of Practice for sterilization of surgical instruments.

42. Additionally, during their investigations, The Joint Commission, CMS, and/or CDPHE reviewed records for the preceding 13-month period and found unacceptably high reports of visible contamination on surgical instruments after sterilization, reflecting Defendant Porter's "[f]ailure to remove gross contaminants from surgical instruments as required by the organization's adopted evidence-based guidelines as evidenced by surgical trays in the operative suite with visible residual bone, hair, and tissue bioburden after the sterilization process."

43. Additionally, during their investigations, The Joint Commission, CMS, and/or CDPHE found evidence of:

a. a lack of disciplinary or corrective action by Defendant Porter;

b. a lack of training and supervision of SPD staff;

c. evidence of staff shortages; and,

d. a failure by Defendant Porter to identify, address, and correct deficiencies.

44. Evidence uncovered by The Joint Commission, CMS, and/or CDPHE and reported in the Surveys, as specified in more detail below, confirmed that this pattern of negligent conduct "seems to go back at least several years, applies to at least the ortho-neuro-spine surgical service and likely several other services, and may have placed patients at risk of acquiring HIV, Hepatitis C, and Hepatitis B, and bacterial surgical site infections."

Investigations Reveal Numerous Specific Failures by Defendant Porter to Follow Relevant Industry Guidelines and Applicable Law

45. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, documented and concluded that Defendant Porter:

a. "failed to ensure surgical services were provided in accordance with established standards, failed to provide oversight of the sterile processing department staff, and failed to identify, track and trend surgical site infections";

b. "failed to provide oversight of the sterile processing department (SPD) staff to ensure equipment was completely cleaned, processed and sterilized appropriately by trained and qualified personnel";

c. "failed to ensure adequate staffing levels were maintained in the sterile processing department (SPD) for the number of surgical cases conducted";

d. "failed to ensure surgical instruments needed for surgeries were sterilized and available for use at the scheduled start time of patients' surgeries";

e. "failed to ensure [Sterile Processing Technicians, or] SPTs contracted for employment in the sterile processing department (SPD) were qualified and met the criteria agreed upon in the contract between the facility and the SPT's employment agency and deemed competent prior to providing services";

f. "failed to provide oversight and ensure sufficient staffing levels in the sterile processing department (SPD) were maintained to ensure appropriate techniques of sterilization process were completed as required. Furthermore, once the facility identified the failure in sterile processing there was no evidence of training or process improvements to avoid further incidents of contamination";

g. "failed to ensure surgical instruments were processed and available for scheduled surgeries, failed to follow manufacturer's instruction for proper

maintenance of instrument washers, and failed to provide oversight of vendor representatives";

h. "failed to ensure instrument washer machines were consistently maintained in accordance with manufacturer's instructions";

i. "failed to ensure outside vendors followed facility policy regarding required attire in the sterile processing department";

j. "failed to provide oversight and ensure vendor loaned surgical instruments were delivered to the facility to be processed by the time required by facility policy";

k. "failed to identify, track, and trend surgical site infections";

l. "failed to ensure staff responsible for infection prevention maintained a consistent process for identifying, investigating and reporting all potential surgical site infections (SSIs)";

m. "failed to analyze data which had been collected to monitor the quality and effectiveness of the sterilization process and decrease the utilization of immediate use steam sterilization (IUSS) to ensure safe services and quality patient care";

n. "identified an increase in surgical site infections (SSIs) . . ." but "failed to follow through with an action plan to decrease SSIs and improve patient outcomes";

o. "failed to ensure surgical services were provided in accordance with established standards of care to ensure positive patient outcomes; specifically related to the routine use of Immediate Use Steam Sterilization (IUSS), a lack of oversight provided to the sterile processing department staff and vendor representatives";

p. "failed to analyze data which had been collected to monitor the quality and effectiveness of the sterilization process and decrease the utilization of immediate use steam sterilization (IUSS) to ensure safe services and quality patient care"; and,

q. "failed to maintain an ongoing quality program that identified and tracked quality data and implemented changes to improve patient outcomes."

46. Defendants were negligent for committing the sterilization failures set forth in paragraph 44(a-q) "for at least several years", by knowingly allowing such failures to continue, and for knowingly failing to properly address and correct these failures.

The Documented Evidence of Improper Sterilization

47. The Joint Commission report dated February 20, 2018 found:

> " . . . in the most recent 13-month time period there were 129 occurrences of incomplete removal of gross surgical contamination as required by the AAMI guidelines followed by the sterile processing department. This was evidenced by visible bioburden such as bone, hair, or tissue, identified on instruments located within sets that had completed the steam sterilization process . . ."

48. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, documented and concluded that Defendant Porter had "identified 76 instances of contaminated surgical instruments and trays, from 1/1/17 to present, which had been processed in SPD and sent to the OR suite to be utilized in surgical cases."

49. In a summary of its findings, the CDPHE found: "On one case report, it was noted that the technician had to open three trays to find one without visible bioburden."

50. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, documented and concluded that "17 of 22 SPD staff members had one or more incidents of documented contamination after the sterilization process which included bone, hair, blood and cement."

51. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, documented and concluded that "Sterile Processing Technician (SPT) #13" had numerous documented incidents involving concerns with trays processed from 1/19/17 to 2/9/18" with "a total of 17 reported incidents."

52. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, documented and concluded that "SPT #18 had 12 incidents from 1/19/17 to 2/9/18 of documented contamination after the sterilization process; such as cement, bone and hair found on instruments or inside the tray."

53. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, documented and concluded that "from 1/25/17 to 1/23/18, SPT #19 had 10 incidents of contamination errors including blood, bone and rust found on the instruments and inside surgical trays."

54. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, documented and concluded that: "Fifteen additional sterile processing department (SPD) employees were identified on the case report logs which identified similar findings of contamination, including bone, hair, blood, and cement."

55. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys and in an incident list report, documented and concluded that there were numerous documented and known violations of sterile processing procedure at Porter Adventist Hospital during the investigated time frame, including:

a. An incident list report documented on 11/16/16: "no [biological] indicator in set";

b. An incident list report documented on 1/2/17: “Bone/Cement in attachment”.

c. An incident list report documented on 1/8/17: “Bone in Kerrison, table redraped scrub down new gloves, caught at set up”;

d. “On 1/19/17 two separate documented incidents of cement found on instruments”;

e. An incident list report documented on 1/19/17: “no [biological] indicator strips inside of tray”;

f. “On 1/24/17 chunks of bone found inside of the pan”;

g. “On 1/25/17 an instrument was noted as clogged with the previous patient’s blood”;

h. An incident list report documented on 1/25/17: “blood on drill bit, didn’t make it to the OR”;

i. “On 1/26/17 blood was found on a drill bit”;

j. An incident list report documented on 1/27/17: “no [biological] indicator”;

k. An incident list report documented on 1/30/17: “cement on freers”;

l. An incident list report documented on 1/30/17: “Particles of bone/unknown white under wrap”;

m. “On 2/16/17 cement was found on the instrumentation”;

n. An incident list report documented on 2/16/17: “cement left on gun” in one operation and “cement on freers” and “Cement on gun” in another operation;

o. An incident list report documented on 2/20/17: “no [biological] indicator in bag”;

p. “On 2/22/17 an incident of blood on a knife handle was noted;”

q. On “3/1/17 cement was found on instrumentation”;

r. “On 3/8/17 visible bone and blood were found in the pan”;

s. “On 3/15/17 an unknown red substance was found in the bottom of the tray”;

t. An incident list report documented on 3/17/17: “old and discolored knife handle”;

u. An incident list report documented on 3/20/17: “Cement on Freer”;

v. “On 3/22/17 bioburden was found while in a surgical case”;

w. On “3/23/17 dirty Kerrisons (spinal surgical instruments) were found in an instrument set during a surgical case”;

x. “On 3/27/17 hair was found on the white wrapping inside a piece of equipment used for knee surgery (knee bump)”;

y. An incident list report documented on 3/27/17: “‘clip found in white bag’ attached to paper, foreign object”;

z. An incident list report documented on 4/12/17: “Missing [Biological] Indicator”;

aa. An incident list report documented on 4/13/17: “piece of foreign material found in bottom of tray”;

bb. “On 4/21/17 blood was found on top of spinal surgical instruments (rainbow curettes)”;

cc. An incident list report documented on 4/27/17: “‘hair found in bottom of tray’ taped to paper”;

dd. An incident list report documented on 5/2/17: “cement on cement gun”;

ee. An incident list report documented on 5/10/17: “no [biological indicator]”;

ff. “On 5/30/17 bone was found in the bottom of a tray”;

gg. “On 6/1/17 an instrument was found to have dried blood on it”;

hh. “On 6/5/17, OR staff documented bioburden was found on a knee bump”;

ii. An incident list report documented on 6/12/17: “Residue under some of the drivers”;

jj. “On 6/14/17 white film was found on an instrument handle”;

kk. “On 6/28/17 black residue was found on an instrument”;

ll. “On 6/29/17 OR staff documented **a dead bug** was found in the surgical tray”;

mm. An incident list report documented on 7/10/17: “Filter dirty”;

nn. “On 7/19/17 . . . cement was found left on instrumentation, all of which was found by OR staff or in the OR suite”;

oo. An incident list report documented on 7/26/17: “Cement on Freer”;

pp. An incident list report documented on 7/27/17: “Cattle tag left in tray”;

qq. An incident list report documented on 8/1/17: “Cement”;

rr. An incident list report documented on 8/3/17: “Hair in tray”;

ss. An incident list report documented on 8/8/17: “Bone in Kerrison”;

tt. On “8/9/17 cement was found on the cement gun (surgical instrumentation)”;

uu. “On 8/11/17 . . . cement was found on the cement gun (surgical instrumentation)”;

vv. An incident list report documented on 8/14/17: “No [biological] indicator”;

ww. On “8/19/17 . . . cement was found left on instrumentation, all of which was found by OR staff or in the OR suite”;

xx. On “8/22/17, cement was found left on instrumentation, all of which was found by OR staff or in the OR suite”;

yy. “On 8/28/17 crusty blood or tissue was found on a surgical instrument”;

zz. “On 9/6/17 cement was found on an instrument”;

aaa. An incident list report documented on 9/7/17: “Cement on Cement gun”;

bbb. “On 9/16/17 cement was found on an instrument”;

ccc. An incident list report documented on 9/21/17: “Blood on keys”;

ddd. An incident list report documented on 10/2/17: “Key had rust on it”;

eee. An incident list report documented on 10/9/17: “Cement on Freers”;

fff. An incident list report documented on 10/10/17: “has blood & chunks on knee bump/wrapper”;

ggg. An incident list report documented on 10/12/17: “Cement on Cement gun”;

hhh. An incident list report documented on 10/19/17: “Cement on gun”;

iii. An incident list report documented on 10/30/17: “Bone in Kerrison”;

jjj. An incident list report documented on 11/9/17: “Questionable material in tray”;

kkk. An incident list report documented on 11/15/17: “Cement on cement gun”;

lll. An incident list report documented on 11/15/17: “missing [biological] indicator”;

mmm. “On 11/22/17 blood from a previous surgical case was found on a piece of an instrument”;

nnn. An incident list report documented on 11/27/17: “Cement on Freers”;

ooo. An incident list report documented on 11/28/17: “Cement on Freer, instrument not clean”;

ppp. An incident list report documented on 12/5/17: “Cement on cement gun”;

qqq. “On 12/5/17 a foreign object (white lock) was documented as being found in a surgical tray”;

rrr. An incident list report documented on 12/6/17: “rust found on knife handles”;

sss. An incident list report documented on 12/6/17: “no [biological] indicator”;

ttt. An incident list report documented on 12/8/17: “Hair in tray”;

uuu. An incident list report documented on 12/12/17: “hair in pan”;

vvv. An incident list report documented on 12/13/17: “water in bottom of pan”;

www. An incident list report documented on 12/13/17: “no [biological] indicator”;

xxx. An incident list report documented on 12/20/17: “Cement on Freers”;

yyy. An incident list report documented on 1/4/18: “Cement on cement gun and freer”;

zzz. An incident list report documented on 1/11/18: “missing [biological] indicator”;

aaaa. An incident list report documented on 1/12/18: “No [biological] indicator”;

bbbb. “On 1/23/18 a piece of bone was found in the bottom of the tray”;

cccc. An incident list report documented on 1/24/17: “baby tonsil was clogged with previous patients’ blood”;

dddd. An incident list report documented on 1/24/17: “previous debris in laser handpiece”;

eeee. An incident list report documented on 1/30/18: “No [biological] indicator”;

ffff. “On 2/19/18 hair was found on surgical instruments.”

gggg. "On 2/27/18 at 10:05 a.m., a tour of the sterile processing department was conducted [and] Vendor #16 was observed setting up clean instruments in trays to be sterilized [but] was not wearing a surgical hair cover and was wearing a personal long sleeve shirt under a surgical scrub top without a surgical scrub jacket."

hhhh. "On 3/12/18 bone was found in the bottom of the tray and 'contaminated' the 'entire setup.'"

iiii. "On 3/1/18 . . . SPT #13 stated SPD staff were currently recleaning, repackaging, and re-sterilizing every instrument in the department due to a recent incident in which surgical instruments were delivered to the OR suite which were not 'up to standards' due to the 'amount of bioburden' on them."

jjjj. "On 3/29/18 'rust/blood' was found on a drill."

kkkk. "On 4/2/18 questionable residue was found on instruments which 'lead to cancellation of surgery.'"

llll. On 4/3/18 a spine surgeon found residue/rust in a rep spine tray. The case was cancelled. No back up instruments available."

mmmm. On 4/4/18, a spine surgeon found residue/rust on spine tray; the case was aborted."

nnnn. On 4/5/18, an "ortho tray was found with residue/rust"; and,

oooo. On 4/5/18, an "ENT tray was found with residue/rust".

56. In an email meeting invitation from Rhonda Witzig, it was documented that on Monday, April 2, 2018 at Porter Adventist Hospital "[s]ome kind of residue/rust was found in Dr. Syre case on Monday in a rep spine pan. The thought is that the instruments were in a plastic caddy and this may be the cause of residue .. ?"

57. In an email meeting invitation from Rhonda Witzig, it was documented that on Tuesday, April 3, 2018 at Porter Adventist Hospital "Dr. Frey found residue/rust in a rep spine tray on Tuesday. The case was cancelled. No back up instruments available."

58. In an email meeting invitation from Rhonda Witzig, it was documented that on Wednesday, April 4, 2018, at Porter Adventist Hospital "Dr. Markey had residue/rust on spine tray; opened and case aborted."

59. In an email meeting invitation from Rhonda Witzig, it was documented that on Thursday, April 5, 2018, at Porter Adventist Hospital there was an "ortho tray with residue/rust (Miner?)".

60. In an email meeting invitation from Rhonda Witzig, it was documented that on Thursday, April 5, 2018, at Porter Adventist Hospital there was an "ENT tray with residue/rust (Nemecek)".

61. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that "There was no documentation of a descaling process (removal of hard deposits formed by chemicals in water) completed on the instrument washers from 10/15/17 to 10/27/17 and 2/24/18 to 3/9/18."

62. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that "the instrument washer operation manual . . . stated it was the responsibility of the customer to perform the decontamination and descaling process on a weekly basis."

63. Each of the documented incidents described in the above paragraph and sub-parts reflects, and is evidence of, a pattern and practice at Porter Adventist Hospital of failing to properly sterilize surgical equipment and instruments, failing to train and supervise Sterile Processing Department and other staff, and failing by the Defendants to address and correct known deficiencies in Sterile Processing.

64. These failures were present throughout all relevant time periods, including all of the Plaintiffs' surgery dates.

Defendant Porter was Using Immediate Use Steam Sterilization ("IUSS") Inconsistently with Industry Standards and Applicable Law

65. Industry safety standards mandate that Immediate Use Steam Sterilization (IUSS) or "flash sterilization" should only be used in emergency situations, such as when a life-threatening surgery must be performed and IUSS of instruments would be required to perform the surgery, or where a physician dropped an instrument during surgery.

66. Defendants routinely and commonly utilized IUSS in violation of industry safety standards, and also in violation of Porter Adventist Hospital policy.

67. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, documented and confirmed that:

a. "On 2/27/18 . . . an oculoplasty set (instrumentation used for surgical procedures involving structures around the eyes) was undergoing an immediate use steam sterilization (IUSS) cycle . . . because it was not sterile at the beginning of the day."

b. Clinical Nursing Specialist #8 reported: "the SPD did not have enough 'man power' to meet the work demand resulting in instruments processed utilizing IUSS."

c. Surgical Clinical Nurse Specialist #8 stated: "she noticed an increase of instruments utilizing IUSS cycles due to the sterile processing department (SPD) not having time to complete a full standard sterilization cycle."

d. Clinical Nursing Specialist #8 stated: "the main reason for the usage of IUSS was due to the inability to complete a full standard sterilization cycle in the SPD in time for the surgical case to begin."

e. Clinical Nursing Specialist #8 stated: "IUSS was not an acceptable practice and should only be used in an emergency."

f. "A review of the IUSS logs, from 1/1/18 to 2/28/18, revealed IUSS was utilized on surgical instruments 60 times."

g. Sterile Processing Department Director #4 stated: that "using IUSS to sterilize surgical instruments was not ideal due to the potential contamination of surgical trays when transporting them from the autoclave to the operating room table."

h. Sterile Processing Department Director #4 stated: "IUSS could also be associated with infection if there was bioburden left on instruments."

i. Infection Prevention Registered Nurse #9 "confirmed the facility followed AORN guidelines in the perioperative area, which included the minimized use of IUSS."

j. Infection Prevention Registered Nurse #9 stated: "the risks involved the utilizing IUSS instead of the standard sterilization process would be contamination and infection."

k. Infection Prevention Registered Nurse #9 acknowledged that "IUSS should only be used in emergency situations; such as a life threatening surgery must be performed and IUSS of instruments was required to perform the surgery or a physician dropped and instrument."

68. Each of the documented incidents described in the above paragraph and sub-parts reflects, and is evidence of, a pattern and practice at Porter Adventist Hospital of improperly using IUSS, failing to comply with hospital policy and industry standard in the sterilization of surgical equipment and instruments, failing to train and supervise Sterile Processing Department and other staff, and failing by the Defendants to address and correct known deficiencies in Sterile Processing.

69. These failures were present throughout all relevant time periods, including all of the Plaintiffs' surgery dates.

Management at Porter Adventist Hospital Was Aware That the Sterile Processing Department Could Not Handle the Amount of Surgeries Scheduled at Porter

70. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Certified Surgical Technician #10 stated: "she frequently had to wait for instruments to be delivered from the SPD at the start of the day."

71. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Certified Surgical Technician #10 stated: "case carts were not always stocked properly because sterile instruments were not ready when they were needed."

72. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Surgical Clinical Nurse Specialist #8 stated: "she was responsible for collecting data regarding immediate use steam sterilization (IUSS) and incidents involving the sterility of surgical instruments delivered to the OR."

73. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Surgical Clinical Nurse Specialist #8 stated: "she noticed an increase of instruments utilizing IUSS cycles due to SPD not having time to complete a full standard sterilization cycle."

74. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Surgical Clinical Nurse Specialist #8: "identified an increase of incidents regarding instruments being opened in the OR with bioburden on them, *specifically blood, bone or cement from a prior case*."

75. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Surgical Clinical Nurse Specialist #8 stated: "she notified her boss (Director #4) about her findings in April 2017."

76. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Surgical Clinical Nurse Specialist #8 stated: "the SPD did not have enough 'man power' to meet the work demand resulting in instruments processed utilizing IUSS."

77. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Surgical Clinical Nurse Specialist #8 stated: "if there was not enough SPD staff available to meet the scheduled work load, the department would always be behind in sterilizing surgical instruments."

78. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Surgical Clinical Nurse Specialist #8 stated: "the main reason for the usage of IUSS was due to the inability to complete a full standard sterilization cycle in the SPD in time for the surgical case to begin."

79. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Surgical Clinical Nurse Specialist #8 stated: "If surgical instruments were not sterilized by the start time of the surgical case . . . staff would at times utilize IUSS and document the reason for IUSS as the 'item was unsterile.'"

80. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that SPD Manager #3 stated: "he was aware there were still

contaminated trays being delivered to the operating room recently after the sterilization process had been completed."

81. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that SPD Manager #3 stated: "'we are short staffed'".

82. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that SPD Manager #3 reported: "we're currently processing instruments for up to 50 cases a day".

83. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further confirmed that SPD Manager #3 reported: "processing instruments for up to 50 cases a day" was a capacity "he considered to be 'not safe.'"

84. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that SPD Manager #3 reported: "'I don't have enough staff'".

85. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that SPD Manager #3 stated: "the sterile processing department was 'severely short staffed.'"

86. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that SPD Manager #3 reported: "he [did] not have time to audit instruments after SPD staff completed the precleaning process and prior to the instruments being sterilized."

87. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that SPD Manager #3 reported: "he did not have time to audit SPD staff performance."

88. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that SPD Manager #3 reported: "the SPD was too understaffed for him to be able to perform manager duties such as audits, monitoring occurrences, orienting new staff and conducting ongoing training and education for current staff."

89. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that SPD "Manager #3 provided a copy of an online listing of current job openings. Open positions were listed as one supervisor, five full-time sterile processing technicians, and one PRN (as needed) technician."

90. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Sterile Processing Technician #1 stated: "the sterile processing department did not have enough staff".

91. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Sterile Processing Technician #1 stated: "she felt she was unable to complete all of her assigned tasks within her shift."

92. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that "On 2/27/18 at 7:44 a.m., operating room (OR) #21 was observed being set for surgical procedure [but] the procedure was delayed, awaiting instruments going through the sterilization process, because of lack of staffing in the sterile processing department."

93. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Supervisor #2 reported: "the sterile processing department was understaffed for the number of scheduled cases needing sterile surgical instruments."

94. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Supervisor #2 reported: "the SPD was unable to catch up on the amount of backlogged instruments in the department needing to be sterilized and the instruments needed for ongoing cases."

95. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that "Chief Nursing Officer #7 reported she was *aware* of inadequate staffing in the sterile processing department for a couple of years, but the facility could not get a handle on staff turnover since April of 2017."

96. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Chief Nursing Officer #7 stated: "she reached out to the chief financial officer after an evaluation of the SPD was conducted and determined the SPD needed 7 positions filled."

97. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Chief Nursing Officer #7 reported: "she had a discussion with the chief medical officer (CMO #6) and decided the 50 surgical cases performed on 2/27/18 (5 days after the start of the Surveys) were too much for the sterile processing department to keep up with and the decision was made to limit surgical cases to a 'manageable workload' with their current resources."

98. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Chief Nursing Officer #7 reported: that the decision to limit surgical cases to a "manageable workload [five days after the Surveys began] was the first time surgical cases were rescheduled due to SPD staffing issues."

99. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Clinical Nursing Specialist #8 reported: "the SPD did not have enough 'man power' to meet the work demand resulting in instruments processed utilizing IUSS."

100. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Chief Nursing Officer #7 stated: issues leading to sterilization issues "were staffing, leadership turnover and leadership oversight for the routine use of IUSS."

101. The Joint Commission and CDPHE investigations, as demonstrated in the Surveys, further documented and confirmed that Chief Nursing Officer #7 stated: "the issues of staffing and leadership oversight were due to leadership turnover and had been present *for two years*."

Defendant Porter is Cited for Multiple Violations of State and Federal Law

102. The surveys conducted by the CDPHE and CMS found Defendant Porter to be in violation of state and federal laws, rules and regulations over an extended period of time.

103. According to the website for CMS: "42 CFR 482 contains the *health and safety requirements* that hospitals must meet to participate in the Medicare and Medicaid programs."[1]

104. CFR 482.12(e)(1) requires: "The governing body must ensure that the services performed under a contract are provided in a safe and effective manner."

105. The Surveys found Defendant Porter in violation of Colorado state regulations, including:

a. 6 CCR 1011-1:II-3.1, Quality Management Program;

b. 6 CCR 1011-1:IV-5.101, Central Medical Surgical Supply Services Organization and Staffing;

c. 6 CCR 1011-1:IV-5.102, Central Medical Surgical Supply Services Programmatic Functions;

d. 6 CCR 1011-1:IV-6.102, Governing Board Programmatic Functions; and,

e. 6 CCR 1011-1:IV-9.101, Infection Control Services Organization and Staffing.

106. The Surveys found Defendant Porter in violation of federal regulations, including:

a. 42 CFR 482.12;

b. 42 CFR 482.12(e)(1);

c. 42 CFR 482.21;

d. 42 CFR 482.42;

e. 42 CFR 482.42(a);

f. 42 CFR 482.51;

g. 42 CFR 482.51(a); and

[1] CMS.gov, Centers for Medicare and Medicaid Services, *Hospitals*, https://www.cms.gov/regulations-and-guidance/legislation/cfcsandcops/hospitals.html (last modified January 21, 2015, 4:14 PM)

h. 42 CFR 482.51(b).

107. Defendant Porter was in violation of state and federal laws, including but not limited to the above-referenced laws, at all times relevant as described herein.

Porter Adventist Hospital Closes its Operating Rooms for Nearly a Week

108. Porter Adventist Hospital closed its operating rooms on April 5, 2018 due to ongoing problems with sterilization of surgical instruments.

109. In an April 11, 2018 statement, Executive Director Dr. Larry Wolk stated the "primary concern" for closing Porter's operating rooms "was with the cleaning process for surgical tools following orthopedic and spine surgeries."

110. Porter Adventist Hospital was required to close its operating rooms due to the findings from The Joint Commission, the CDPHE, and CMS.

111. Defendant Porter was prohibited from resuming any surgeries in its operating rooms until and unless it received approval from The Joint Commission, CDPHE, and/or CMS.

112. The closing of its operating rooms for a 6-day period was a public acknowledgment by Defendant Porter that it had a systemic sterilization problem that endangered patients and increased risk of patient harm.

Porter Notifies Patients of Increased Risk of Harm Caused by Improper Sterilization

113. Defendant Porter, through a press release, claimed that the ORs were closed after it "noticed a potential change in our water quality relative to our surgical equipment".

114. The CDPHE considered "contaminated water leaving residue on instruments" to be a "potential concern" with contamination at Porter Adventist Hospital.

115. The CHDPHE concluded, as reflected in the Surveys, that the "primary concern" with contamination at Porter Adventist Hospital's was "the cleaning process for surgical tools following orthopedic and spine surgeries."

116. During an April 6, 2018 phone call between Defendant Porter and the CDPHE, the minute notes reflect that "Denver water reported that water is within normal parameters."

117. In response to the chronic contamination problems revealed by the surveys, Defendant Porter agreed to notify all patients who had orthopedic or spine surgery at Defendant Porter between July 21, 2016 and April 5, 2018 that they may be at risk for SSIs and blood borne infections like HIV, hepatitis C, and hepatitis B.

118. On April 4, 2018, Defendant Porter began notifying patients who had orthopedic or spine surgery at Defendant Porter between July 21, 2016 and April 5, 2018 that they were exposed to an elevated risk of bacterial SSIs and blood borne pathogens such as HIV, hepatitis C, and hepatitis B.

119. Despite knowing that Porter Adventist Hospital had problems with sterilization and contamination, Defendants continued to market and sell their surgical services to patients and physicians.

The Federal and State Government Entities Found Defendant Porter's Failures are Causally Connected to Harm to Patients

120. In a summary of its findings, the CDPHE documented and determined: "Incorrect cleaning, disinfection, and sterilization of surgical instruments can lead to SSIs and bloodborne pathogen transmission."

121. In a summary of its findings, the CDPHE documented and determined: "Bioburden found on surgical tools following orthopedic and spine procedures at PAH may pose an increased risk of SSIs, and in fact, there were increases in SSIs in hip replacements and fusions during 2016-2017."

122. In a summary of its findings, the CDPHE documented and determined: "'surface bioburden to any degree facilitates the formation of biofilm [and] biofilms can also be microscopic and can develop on the surfaces of medical devices and equipment very rapidly (within minutes).'"

123. In a summary of its findings, the CDPHE documented and determined: "The presence of bioburden and possible biofilm is concerning in that it may increase the risk of SSI."

124. In a summary of its findings, the CDPHE documented and determined: "The magnitude of the increased risk of SSI and bloodborne pathogens in this scenario is unknown, but it is *higher than baseline risk*."

125. In a summary of its findings, the CDPHE documented and determined: "the increased SIRs in some ortho/neuro/spine infections to the infection control breaches during the reprocessing of ortho/neuro/spine surgical instruments, the temporal association is concerning."

126. In a summary of its findings, the CDPHE documented and determined: "A review of TJC Quick Safety bulletin from May 2014 suggests that it is not common for TJC to find similar errors [as those at Porter Adventist Hospital] deemed to be an 'immediate threat to life.'"

127. In a summary of its findings, the CDPHE documented and determined: "Of all facilities (not just hospitals) in 2013, only 13 were deemed to be an 'immediate threat to life' (note that TJC serves approximately 21,000 healthcare facilities)."

128. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, documented and concluded that Defendant Porter:

a. "failed to maintain an ongoing quality program that identified and tracked quality data and implemented changes to improve patient outcomes. This failure resulted in ongoing incidents in which contaminated surgical instruments were being delivered to the operating room (OR) for surgical cases and potentially contributed to an increase in surgical site infections and adverse patient events."

b. "failed to maintain an ongoing quality program that identified and tracked quality data and implemented changes to improve patient outcomes. This failure resulted in ongoing incidents in which contaminated surgical instruments were being delivered to the operating room (OR) for surgical cases and potentially contributed to an increase in surgical site infections and adverse patient events."

c. "failed to ensure surgical services were provided in accordance with established standards of care to ensure positive patient outcomes; specifically related to the routine use of Immediate Use Steam Sterilization (IUSS), a lack of oversight provided to the sterile processing department staff and vendor representatives. Additionally, the facility failed to identify, track, and trend surgical site infections. This failure resulted in ongoing use of IUSS and the potential for transmission of healthcare acquired infections. Additionally, the failure resulted in surgical site infections not being investigated and reported to identify potential trends and areas for improvement."

d. "failed to provide oversight and ensure sufficient staffing levels in the sterile processing department (SPD) were maintained to ensure appropriate techniques of sterilization process were completed as required. Furthermore, once the facility identified the failure in sterile processing there was no evidence of training or process improvements to avoid further incidents of contamination. This failure resulted in the delivery of numerous contaminated surgical instruments to operating room staff for use in surgical cases."

e. "failed to ensure surgical instruments were processed and available for scheduled surgeries, failed to follow manufacturer's instruction for proper maintenance of instrument washers, and failed to provide oversight of vendor representatives. This failure resulted in the routine use of immediate use steam sterilization (IUSS) and the potential for transmission of healthcare acquired infections."

f. "failed to provide oversight and ensure sufficient staffing levels in the sterile processing department (SPD) were maintained to ensure appropriate techniques of sterilization process were completed as required. Furthermore, once the facility identified the failure in sterile processing there was no evidence of training or process improvements to avoid further incidents of contamination. This failure resulted in the delivery of numerous contaminated surgical instruments to operating room staff for use in surgical cases."

g. "failed to ensure surgical services were provided in accordance with established standards, failed to provide oversight of the sterile processing department staff, and failed to identify, track and trend surgical site infections. These failures resulted in the ongoing prevalence of incidents where surgical instruments were not completely cleaned and sterilized for use in surgical cases, the routine

utilization of immediate use steam sterilization (IUSS), and surgical site infections not being investigated and reported to identify potential trends and areas for improvement."

h. "failed to maintain an ongoing quality program that identified and tracked quality data and implemented changes to improve patient outcomes."

129. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, documented and concluded that Defendant Porter's failures "resulted in ongoing incidents in which contaminated surgical instruments were being delivered to the operating room (OR) for surgical cases and potentially contributed to an increase in surgical site infections and adverse patient events."

As a Result of Defendant Porter's Practices, Contaminated Instruments Were Used in Surgeries

130. As a result of the above-described practices at Porter Adventist Hospital from at least early-2015 through late 2018, surgical instruments delivered to Porter Adventist Hospital operating rooms were frequently contaminated with both visible and microscopic contaminants.

131. At all relevant times, surgical instruments contaminated with visible and microscopic contaminants were used in surgeries, including the Plaintiffs' listed herein.

132. At all relevant times, surgical instruments contaminated with visible and microscopic contaminants compromised surgical asepsis and placed surgical patients, including the named Plaintiffs, at undue risk of infection.

133. The use of contaminated instruments in the Plaintiffs' surgeries directly and proximately caused them –except Plaintiffs Lovett and Krasowski—to develop surgical site infections, as described in more detail below.

134. The contamination of surgical instruments caused by improper cleaning/sterilization directly and proximately caused Plaintiffs Lovett and Krasowski to suffer aborted surgical procedures, as described in more detail below.

The AORN Guidelines for Perioperative Case Codify the Industry Standards for Surgical Instrument Sterilization and Surgical Site Infection Reporting

135. The Association of Perioperative Registered Nurses (AORN), Guidelines for Perioperative Practice ("AORN Guidelines") codify the standard of care related to, among other things: surgical instrument sterilization; the use of Immediate Use Steam Sterilization; reporting of Surgical Site Infections; and, hiring and training of perioperative team members with responsibilities for cleaning and care of instruments.

136. Defendant Porter was obligated, and required by industry standards of practice, to comply with the AORN Guidelines for Perioperative Practice.

137. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, documented and concluded that:

a. The AORN Guidelines, Recommendation I, prescribes that: "When critical items are contaminated with microorganisms, including bacterial spores, the risk of infection is substantial. Examples of critical items are surgical instruments."

b. The "AORN Guidelines, Recommendation II, prescribes that: "Items should be thoroughly cleaned and decontaminated before high-level disinfection. Cleaning and decontamination are the initial and most critical steps in breaking the chain of disease transmission. Debris, blood, mucus, fat, tissue, and organic matter will interfere with the action of the disinfectant."

c. The AORN Guidelines, Recommendation VII, prescribes that: "IUSS [Immediate Use Steam Sterilization] may be associated with an increased risk of infection to patients and should be kept to a minimum."

d. The AORN Guidelines, Recommendation X, prescribes that: "Surgical instruments should be inspected and evaluated for cleanliness after decontamination and if soiled should be removed from service until they are cleaned. Items that are not clean can put a patient at risk for injury or surgical site infection (SSI). Use of instruments that are not thoroughly cleaned, poses a risk to patient safety."

e. The AORN Guidelines, Recommendation XV, prescribes that: "Perioperative team members with responsibilities for cleaning and care of instruments used in surgery should receive initial and ongoing education and complete competency verification activities relate to cleaning and care of surgical instruments. Ongoing education and competency validation of perioperative personnel facilitate the development of knowledge, skills, and attitudes that affect patient and worker safety."

138. In a May 9, 2018 letter from the CDPHE to Group Chief Financial Officer of Porter Adventist Hospital, Andrew Gaasch, the CDPHE documented and identified specific deficiencies in sterilization practices at Porter Adventist Hospital and instructed Mr. Gaasch and Defendant Porter as to corrective measures that were required.

139. In the May 9, 2018 letter, specifically, but without limitation, CDPHE instructed that, pursuant to the AORN Guidelines of 2018:

a. "Instruments should be cleaned and decontaminated as soon as possible after use. When blood or other bioburden is allowed to dry on instruments, it can become more difficult to remove."

b. “During the procedure, the scrub person should remove gross soil from instruments by wiping the surfaces with a sterile surgical sponge moistened with sterile water. Gross soil left to dry on instruments can affect the efficacy of subsequent disinfection and sterilization processes.”

c. “Instruments that cannot be cleaned immediately should be treated with an instrument cleaner according to the device and the instrument cleaner manufacturers’ written IFU.”

d. “Blood, organic material, debris, and saline are highly corrosive to instrument surfaces and can cause corrosion, rusting, and pitting when allowed to dry on surgical instruments, these materials can be difficult to remove from all surfaces during the cleaning and decontamination process, reducing the efficacy of the subsequent sterilization process.”

e. “When an instrument is composed of more than one piece, it should be opened and disassembled according to the manufacturer’s written IFU and arranged in a manner that will permit contact of cleaning solutions with all surfaces of the instruments.”

f. “The manufacturer’s written IFU should be readily available to the personnel responsible for processing instruments and devices used for surgical or other procedures performed in the facility.”

g. “Lighted magnification should be used to inspect hard-to-clean areas of devices for cleanliness. An instrument that appears clean to the naked eye may harbor debris that cannot be seen without magnification. This should occur in both decontamination and sterilization.”

h. “Surgical instruments should be inspected and evaluated for cleanliness and correct working order after decontamination and if soiled or defective, should be removed from service until they are cleaned or repaired. Items should be inspected and evaluated for:

   i. Cleanliness;

   ii. Correct alignment;

   iii. Corrosion, pitting, burrs, nicks, cracks;

   iv. Sharpness of cutting edges;

   v. Wear and chipping of inserts and plated surfaces;

   vi. Missing parts;

   vii. Integrity of insulation on insulated devices;

viii. Integrity of cords and cables;

ix. Clarity of lenses;

x. Integrity of seals and gaskets;

xi. Presence of moisture;

xii. Correct functioning; and

xiii. Other defects."

i. "Instruments should be rinsed in cool water before washing. Hot water can denature blood proteins, which makes them more difficult to remove. Cool water can help to prevent coagulation of blood on instruments and can help remove gross soil from lumens, joints, and crevices. The type of water used for cleaning should be consistent with the manufacturer's written IFU and the intended use of the equipment and cleaning produce."

j. "Surgical instrument, cleaning product, and cleaning equipment manufacturers' validated, written IFU should be reviewed for compatibility during selection and followed during use of cleaning products and equipment for cleaning and decontaminating surgical instruments."

k. "Documentation of instrument cleaning and disinfection processes should be maintained."

l. "Immediate use steam sterilization (IUSS) should be kept to a minimum and should be used only in selected clinical situations and in a controlled manner. IUSS may be associated with increased risk of infection to patients."

m. "The health care organization should hold the executives and managers at all levels accountable for promoting a patient safety culture."

n. "The health care organization should establish administrative processes to create a patient safety culture and encourage individual team members to actively engage in and support the culture. In a patient safety culture, perioperative team members reduce risk by communicating safety concerns."

o. "The health care organization should implement clear, just, and transparent processes for recognizing human and system errors and distinguishing these from unsafe, blameworthy actions."

p. "Perioperative nurses should contribute to creating a culture of safety."

q. "Personnel should receive initial and ongoing education and complete competency verification activities related to team communication and a patient safety culture."

r. “The health care organization’s quality management program should evaluate the cleaning, decontamination, and care of instruments. These programs provide data that may be used to determine whether an individual organization is whiting benchmark goals and, if not, to identify areas that may require corrective actions.”

s. “Policies and procedures for cleaning and care of instruments used in surgery should be developed, reviewed periodically, revised as necessary, and readily available in the practice setting in which they are used.”

t. “Adverse events should be reported and documented according to the health care organization’s policy and procedure and should be reviewed for potential opportunities for improvement.”

Defendant Porter Made Misrepresentations to the Public and its Patients

140. Upon information and belief, Defendant Porter made the following representations, or words to the same effect, in their advertisements to the public at large on their website regarding the quality and value of their services:

a. “We consistently deliver exceptional care and strive for excellence in all we do.”

b. “We are called to uphold the highest standards, with integrity driving every decision we make and every action we take.”

c. “Our leading-edge teams deliver remarkable care, high-quality outcomes and unparalleled patient satisfaction among a wide variety of medical specialties, services and programs to help you get well and stay well.”

d. “As the region’s leading health care provider, Centura Health is firmly committed to quality and patient safety.”

e. “As the region’s leading health care provider, we are committed to clinical excellence and superior outcomes.”

f. “Defendant Porter Adventist Hospital is dedicated to providing innovative, quality treatment for orthopedic conditions.”

g. “At Porter Adventist Hospital, patient safety and clinical quality is always our top priority and our single most important job.”

h. “We uphold and enforce the highest medical standards, the most rigorous clinical requirements, and we maintain an unwavering commitment to patient safety.”

i. "[O]ur dedicated orthopedic operating rooms are among the most sophisticated, sterile and state-of-the-art surgical suites..."

141. The same or similar statements above were present on Defendant Porter's website and/or promotional materials from January 2015 through the date of the filing of this Complaint.

142. In a letter dated April 6, 2018, Defendant Porter informed prior patients of Porter Adventist Hospital who had "an orthopedic or spine surgical procedure between July 21, 2016 and April 5, 2018" of their "risk of surgical site infection or bloodborne pathogen transmission".

143. In a letter dated April 6, 2018 to prior patients of Porter Adventist Hospital, Defendant Porter made the following statements:

a. "patient safety is our top priority";

b. "We recently identified a gap in our precleaning process prior to sterilization of instruments that occurred during this time.";

c. "we track infections";

d. "we . . . have found no evidence of patient harm";

e. "We understand this news may cause concern"; and,

f. "recent survey results released by the Joint Commission, which accredits hospitals in the United States, revealed no errors in our processes or protocols."

144. In an April 11, 2018 "Statement from Executive Director Dr. Larry Wolk" for an "[u]pdate regarding the infection control breach at Porter Adventist Hospital", he stated: "Through its investigation into the infection control breach at Porter Adventist Hospital, the department has now learned of a number of patients who had surgical site infections after orthopedic or spine surgery at Porter between July 21, 2016 and April 5, 2018."

145. In 2015, 2016, 2017, and 2018, Defendants received and were aware of reports of surgeons and medical staff of "visible bioburden such as bone, hair, or tissue, identified on instruments that had completed the steam sterilization process."

146. Porter Adventist Hospital experienced an increase in surgical site infections of approximately 300% during the relevant time period.

147. The CDPHE noted in its April 3, 2018 report that "CDPHE continues to voice concerns that there are misleading statements in the [patient notification] letter."

148. In an April 11, 2018 "Statement from Executive Director Dr. Larry Wolk" for an "[u]pdate regarding the infection control breach at Porter Adventist Hospital", he stated:

> **"**On April 5, Porter voluntarily closed its operating rooms for two reasons. The primary concern was with the cleaning process for surgical tools following

> orthopedic and spine surgeries. The other potential concern related to residue on surgical tools after sterilization. Porter reported this was potentially due to a water quality issue. As a result, water testing was conducted, and water quality at Porter was found to be well within the typical range found in drinking water."

149. During an April 6, 2018 phone call between Defendant Porter and the CDPHE, the minute notes reflect that "Denver water reported that water is within normal parameters."

150. In a meeting with Defendant Porter and government representatives, Wendy Bamberg of the Centers for Disease Control and Prevention was noted as stating that the patient notification letter related to sterilization breaches contained comments "we felt were misleading".

151. In a meeting with Defendant Porter and government representatives, Wendy Bamberg of the Centers for Disease Control and Prevention stated, "we feel that this statistic is misleading" regarding the SSI rate calculation proffered by Defendant Porter.

152. Evidence uncovered by The Joint Commission and CDPHE documented and confirmed that this pattern of negligent conduct "seems to go back ***at least several years***, applies to at least the ortho-neuro-spine surgical service and *likely several other services*, and may have placed patients at risk of acquiring HIV, Hepatitis C, and Hepatitis B, and bacterial surgical site infections."

Defendant Porter was Underreporting its Surgical Site Infections to the Relevant Government Authorities

153. Defendant Porter knew that it was required by state and federal law to track, investigate, and report SSIs at each of its hospital facilities, including Porter Adventist Hospital.

154. Defendant Porter had a duty to the consumer public and patients, including Plaintiffs, to comply with state and federal laws regarding tracking, investigating and reporting of infections.

155. As part of the investigations, The Joint Commission, CMS, and/or CDPHE reviewed Defendant Porter's reporting of infections and documented and concluded that Defendant Porter had failed to properly and accurately report infections, including Surgical Site Infections.

156. Defendant Porter emailed its position regarding infection rates to the CDPHE, stating:

> "In fact, the surgical site infection rates at [Porter Adventist Hospital] are well below national standards and expected rates of surgical site infections. [Porter Adventist Hospital] had a surgical site infection rate of 0.35% in 2017 - well below the 2-5% cited by the Society for Healthcare Epidemiology of America and the Infectious Disease Society of America as expected rates of SSI following inpatient surgery."

157. Defendant Porter's purpose for making the above-referenced statement was to mislead and/or detract the CDPHE from recognizing a causal connection between its sterilization problems and increased SSIs.

158. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, documented and concluded that Defendant Porter had failed to properly and/or accurately report surgical site infections as required by state and federal law.

159. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, documented and concluded that, despite meeting the criteria for an SSI, "Patient A was not listed as being reported for having an SSI."

160. The Joint Commission, CMS, and/or CDPHE investigations, as demonstrated in the Surveys, documented "Seven additional patients [who] were identified as meeting criteria for having a reportable SSI on the 2018 SSI document", about whom Defendant Porter failed to report.

161. As reported in the Surveys, Porter Vice President of Quality #20 "acknowledged the facility's current investigation and tracking of SSIs was not effective".

162. As reported in the Surveys, Porter Vice President of Quality #20 stated that Porter Adventist Hospital had "'missed the boat.'"

163. As reported in the Surveys, Porter Vice President of Quality #20 stated that "there was no standard tracking format and the individual responsible for the process was not competent to identify, investigate and track surgical site infections."

164. Defendant Porter negligently failed to properly track infections, negligently failed to properly investigate and address increases in infections, and negligently failed to accurately report infections to licensing and regulatory entities.

165. Defendant Porter experienced increases (surges) in surgical site infections in 2015, 2016, 2017, and 2018.

166. Defendant Porter knowingly concealed its ongoing sterilization and infection control breach from licensing and regulatory authorities by manipulating data, withholding required patient information, failing to properly report, as well as utilizing incompetent individual(s) and ineffective systems for identifying, investigating, and tracking SSIs.

167. Additionally, Defendant Porter knowingly failed to timely and properly address known increases in surgical site infections.

168. Defendant Porter's leadership:

a. failed to hold quality control meetings;

b. failed to create documentation of identifying and addressing infection control problems;

c. failed to communicate its ongoing infection control problems with licensing and regulatory authorities;

d. failed to create and follow up with action plans to correct deficiencies in infection control; and,

e. failed to address problems with staffing in the SPD and other employees involved in sterilization and infection control.

169. As a result of Defendant Porter's knowing concealment of its sterilization and infection control breach, the consumer public, including the surgeons who operated on the Plaintiffs and Plaintiffs themselves, were not aware that Porter Adventist Hospital's surgical services presented an undue risk to patients.

Defendant Porter Failed to Address the Systemic and Systematic Sterilization and Surgical Site Infection Reporting Deficiencies

170. The Surveys documented that Chief Nursing Officer #7 stated: "the issues of staffing and leadership oversight were due to leadership turnover and had been present *for two years*."

171. In a summary of notes related to the sterilization breaches with Porter Adventist Hospital, the notes reflect that "CDPHE interviews determined that this was a regular occurrence that has *been ongoing for at least 2 years* based on employee interviews."

172. In a summary of notes related to the sterilization breaches with Porter Adventist Hospital, the notes reflect that the CDPHE "team reviewed 'case reports' requested and found 80+ incidents of either gross contamination or no sterile indicator in tray, we are getting clarification on time period of these reports. We requested 6 months but believe this is not accurate. (Received large stack of paper clipped papers in no apparent date order etc.)".

173. The Surveys documented that Interim Director of Quality #28 stated: "the value optimization team reviewed the Case Reports [documenting issues of bioburden] as a way to measure the success of the project and identify 'defects' (variations) from the improvement process [but] they were not being reported to the quality department."

174. The Surveys documented that Interim Director of Quality #28 stated: "the optimization team did not look at the case reports with a patient 'safety lens.'"

175. The Surveys documented that Interim Director of Quality #28 stated: "we were not effective or efficient on acting" on sterilization issues identified on the case reports as she was not aware of them.

176. The Surveys documented that Surgical Clinical Nurse Specialist #8 stated: "a LEAN project was created related to the findings of ongoing IUSS utilization and contaminated instruments . . . but was not aware of any ongoing discussions about the project since May 2017."

177. The Surveys documented that: "personnel file review of five contracted [Sterile Processing Technicians (SPTs)] (#25, #26, #29, #30, and #31) showed that although each employee had filled out a self evaluation there was no evidence the facility had evaluated the SPTs to ensure they were competent in duties there were assigned in the sterilization process."

178. The Surveys determined that: "once the facility identified the failure in sterile processing there was no evidence of training or process improvements to avoid further incidents of contamination."

179. The Surveys documented and determined that: "there was no documentation the facility had identified the ongoing issue of contamination within SPD and implemented corrective actions in order to improve quality and patient safety and reduce the likelihood and risk of sentinel events and other adverse events."

180. The Surveys documented and determined: "The facility identified an increase in surgical site infections (SSls). However, the facility failed to follow through with an action plan to decrease SSls and improve patient outcomes."

181. The Surveys documented that: "A review of the Infection Prevention Committee minutes from 6/20/17 revealed an increase in hip and spine SSls was first communicated to the committee in January 2017."

182. The Surveys documented that: The Infection Prevention Committee "identified the rate of spinal SSIs had not improved since January 2017."

183. The Surveys documented that: "The corporate director of quality and patient safety (Director #23) acknowledged there was no documentation of monthly meetings and confirmed there were only two meetings held to review the action plan."

184. The Surveys documented that: "two monthly action plan review meetings identified possible interventions for reducing spinal SSIs" but there "was no further documentation to show if these interventions had been implemented, assessed or evaluated for effectiveness."

185. The Surveys documented that: "according to the 2018 SSI document, there were eight patients identified with reportable spinal SSIs between 10/10/17 and 1/24/18 with no follow up from the monthly action plan review committee."

186. The Surveys documented that Interim Director of Quality (Director #28) stated: she "had identified concerns with the infection prevention program and was in the process of making some changes. However, Director #28 stated she had not instituted any changes at the time of the Surveys."

187. The Surveys determined: "There was no documentation the SPD staff were retrained and had their competency evaluated to ensure contaminated instruments were completely cleaned, processed, and sterilized."

188. The Surveys documented that SPD Manager #3 stated: "there was only one staff member with case reports who received *any* corrective action."

189. The Surveys documented that SPD Manager #3 stated: "none of the SPD staff members received any re-education or training on sterilization processes."

190. The Surveys documented that: "Director #4 stated shift reports were detailed verbal team meeting discussions and all staff were expected to read and sign to ensure staff had received the education [but] the shift reports reviewed showed no evidence of training or process changes implemented from contamination issues identified in the case reports."

191. The CDPHE documented in its March 26, 2018 report that during "multiple phone meetings with Porter/Centura to identify the risk period and patient population at risk due to breaches in infection control in sterile processing" that "Porter has not communicated agreement with the CDPHE and CDC opinion on risk to patients."

192. The CDPHE documented in its April 3, 2018 report that on a "coordination call with Porter, the content and wording of the [patient] notification was primarily discussed" and "CDPHE representatives voiced their concern" that "some of the information in the correspondence minimized the issue at hand."

193. The CDPHE documented in its April 3, 2018 report that "CDPHE continues to voice concerns that there are misleading statements in the letter."

194. In a meeting with Defendant Porter and government representatives, Wendy Bamberg of the Centers for Disease Control and Prevention was documented as stating that the "Centura lawyer sent [an] email about why notification was not necessary" to potentially affected patients.

195. During an April 6, 2018 phone call between Defendant Porter and the CDPHE, the minute notes reflect that "CDPHE further recommends that Porter update their media info, which Porter also declined to do."

196. During an April 6, 2018 phone call between Defendant Porter and the CDPHE, the minute notes reflect that "CDPHE recommends that Porter update their statement on the website today, notifying the patients of the identified ongoing risk[]" but "Porter resistant to updating their statement."

IV. PLAINTIFFS' SURGERIES, DISCOVERY OF THEIR INFECTIONS, AND THEIR CAUSES

Plaintiffs' Surgeries and the Resulting Infections

1. Plaintiff Robert Philippe's surgical site infection of April 15, 2015

197. Plaintiff Robert Philippe ("Mr. Philippe") was scheduled for total right knee arthroplasty surgery and his surgeon, Dr. Douglas Dennis, M.D., proposed that Plaintiff Mr. Philippe undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

198. Dr. Douglas Dennis, M.D. performed the total right knee arthroplasty surgery at Porter Adventist Hospital on April 15, 2015 without apparent complication.

199. After his surgery, Plaintiff Mr. Philippe began to experience effusion and decreased range of motion around his surgical wound, such that Dr. Jason Jennings, M.D. aspirated his right knee.

200. The results from cultures taken from Plaintiff Mr. Philippe's surgical site diagnosed Plaintiff Mr. Philippe with a surgical site infection pathogen of rare Staphylococcus aureus.

201. On July 6, 2016, Dr. Jennings performed on Plaintiff Mr. Philippe a right knee explantation of a total knee arthroplasty and inserted antibiotic beads and knee spacers, as well as an irrigation and debridement of the right knee.

202. As a result of Plaintiff Mr. Philippe's rare Staphylococcus aureus infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Philippe to suffer associated economic and noneconomic damages.

2. Plaintiff Michael Pitcock's surgical site infection of October 6, 2015

203. Plaintiff Michael Pitcock ("Mr. Pitcock") was scheduled for a left total knee arthroplasty surgery and his surgeon, Dr. Raymond Kim, M.D., proposed that Plaintiff Mr. Pitcock undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

204. Dr. Raymond Kim, M.D. performed the left total knee arthroplasty surgery at Porter Adventist Hospital on October 6, 2015 without apparent complication.

205. After his surgery, Plaintiff Mr. Pitcock began to experience redness and pain around his surgical wound, such that Dr. Raymond Kim, M.D. performed a knee replacement revision with insertion of antibiotic spaces surgery March 24, 2016.

206. The results from cultures taken from Plaintiff Mr. Pitcock's surgical site diagnosed Plaintiff Mr. Pitcock with a surgical site infection pathogen of Staphylococcus aureus.

207. As a result of Plaintiff Mr. Pitcock's Staphylococcus aureus infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Pitcock to suffer associated economic and noneconomic damages.

208. At all times relevant, Plaintiff Mr. Pitcock was married to his spouse, Plaintiff Harrilyn Pitcock.

209. Plaintiff Mr. Pitcock's surgical site infection caused his spouse, Plaintiff Harrilyn Pitcock, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

3. Plaintiff Renae Steinbech's surgical site infections of February 19, 2016, April 29, 2016, June 17, 2016, November 8, 2017, December 1, 2017, December 24, 2017, February 17, 2018, and March 26, 2018

210. Plaintiff Renae Steinbech ("Ms. Steinbech") was scheduled for metatarsal osteotomy and fusion surgery and her surgeon, Dr. Edward Raczka, D.P.M., proposed that Plaintiff Ms. Steinbech undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

211. Dr. Edward Raczka, D.P.M. performed the cervical fusion surgery at Porter Adventist Hospital on February 19, 2016 without apparent complication.

212. After her surgery, Plaintiff Ms. Steinbech began to experience pain and drainage from her surgical site wound, such that Dr. Edward Raczka, D.P.M. performed a closure of the wound with an opening and drainage surgery on April 29, 2016.

213. The results from cultures taken from Plaintiff Ms. Steinbech's surgical site diagnosed Plaintiff Ms. Steinbech with a surgical site infection pathogen of Staphylococcus aureus.

214. Subsequently, Dr. Edward Raczka, D.P.M. performed a metatarsal neurectomy surgery on Plaintiff Ms. Steinbach on June 17, 2016 at Porter Adventist Hospital.

215. After Plaintiff Ms. Steinbach's June 17, 2016 surgery, she experienced erythema and purulent drainage from her surgical site wound, resulting in a diagnosis of a cellulitis infection.

216. Then, Dr. Edward Raczka, D.P.M. performed a metatarsal surgery on Plaintiff Ms. Steinbach on November 8, 2017 at Porter Adventist Hospital.

217. After Plaintiff Ms. Steinbach's November 8, 2017 surgery, she was diagnosed with an infection with a confirmed pathogen of Staphylococcus aureus.

218. As a result of her infection from her November 8, 2017 surgery, on December 1, 2017, Dr. Edward Raczka, D.P.M. performed an irrigation and debridement at Porter Adventist Hospital, after which her cultures grew Methicillin-sensitive Staphylococcus aureus and anaerobes pathogens.

219. In an irrigation and debridement surgery due to her infection, performed by Dr. Edward Raczka, D.P.M. on December 24, 2017 at Porter Adventist Hospital, her cultures grew Methicillin-sensitive Staphylococcus aureus and diphtheroids pathogens.

220. On February 17, 2018, Dr. Edward Raczka, D.P.M. performed a grafting surgery on Plaintiff Ms. Steinbach.

221. After her February 17, 2018 surgery, Ms. Steinbach experienced foul smelling drainage from her surgical site wound and her cultures taken from the wound grew Methicillin-sensitive Staphylococcus aureus and enterobacter cloacae pathogens.

222. Then, on March 26, 2018, Plaintiff Ms. Steinbach had a resection surgery at Porter Adventist Hospital and she was subsequently diagnosed with a surgical site infection with diagnosed pathogens of Diphtheroids, Rare Klebsiella pneumoniae complex, Enterobacter cloacae, and Methicillin-sensitive Staphylococcus aureus.

223. As a result of Plaintiff Ms. Steinbech's numerous surgical site infections, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Steinbech to suffer associated economic and noneconomic damages.

4. Plaintiff Julie Schultz Duff's surgical site infections of June 27, 2016 **and** *June 27, 2017*

224. Plaintiff Julie Schultz Duff ("Ms. Schultz Duff") was scheduled for total left hip replacement surgery and her surgeon, Dr. Charlie Yang, M.D., proposed that Plaintiff Ms. Schultz Duff undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

225. Dr. Charlie Yang, M.D. performed the total left hip replacement surgery at Porter Adventist Hospital on June 27, 2016 without apparent complication.

226. After her surgery, Plaintiff Ms. Schultz Duff began to experience effusion and decreased range of motion around her surgical wound, such that Dr. Charlie Yang, M.D. aspirated her hip on July 25, 2016.

227. The results from cultures taken from Plaintiff Ms. Schultz Duff's surgical site was not diagnosed with a specific pathogen, but she was diagnosed with cellulitis.

228. As a result of Plaintiff Ms. Schultz Duff's cellulitis infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Schultz Duff to suffer associated economic and noneconomic damages.

229. Subsequently, Plaintiff Julie Schultz Duff ("Ms. Schultz Duff") was scheduled for cervical decompression and laminectomy surgery and her surgeon, Dr. George Frey, M.D., proposed that Plaintiff Ms. Schultz Duff undergo this surgical procedure at Porter Adventist Hospital in Denver, Colorado as well.

230. Dr. George Frey, M.D. performed the cervical decompression and laminectomy surgery at Porter Adventist Hospital on June 27, 2017 without apparent complication.

231. After Plaintiff Ms. Schultz Duff began to experience pain and drainage from her surgical wound, she received an irrigation and debridement at Swedish Medical Center.

232. The results from cultures taken from Plaintiff Ms. Schultz Duff's surgical site was not diagnosed with a specific pathogen.

233. As a result of Plaintiff Ms. Schultz Duff's undiagnosed pathogen infection, she required additional hospitalizations for medical complications, surgery and other procedures, antibiotics, and caused Plaintiff Ms. Schultz Duff to suffer associated economic and noneconomic damages.

5. Plaintiff Kate Fields' surgical site infection of June 11, 2016

234. Plaintiff Kate Fields ("Ms. Fields") was scheduled for total knee arthroplasty surgery and her surgeon, Dr. Douglas Dennis, M.D., proposed that Plaintiff Ms. Fields undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

235. Dr. Douglas Dennis, M.D. performed the total knee arthroplasty surgery at Porter Adventist Hospital on June 11, 2016 without apparent complication.

236. After her surgery, Plaintiff Ms. Fields began to experience fever, tachycardia, wound dehiscence, left foot pain, change in color to her left leg, and some purulent drainage from her surgical wound, such that Dr. Charlie Yang, M.D. performed an irrigation and debridement.

237. The results from cultures taken from Plaintiff Ms. Fields' surgical site diagnosed Plaintiff Ms. Fields with a surgical site infection pathogen of Group B Streptococcus agalactiae.

238. As a result of Plaintiff Ms. Fields' Group B Streptococcus agalactiae infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Fields to suffer associated economic and noneconomic damages.

239. At all times relevant, Plaintiff Ms. Fields was married to her spouse, Plaintiff Dale Fields.

240. Plaintiff Ms. Fields' surgical site infection caused her spouse, Plaintiff Dale Fields, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

6. Plaintiff Sandra Dohallow's infection of August 5, 2016

241. Plaintiff Sandra Dohallow ("Ms. Dohallow") was scheduled for a left hip intramedullary nail placement surgery and her surgeon, Dr. Ryan Carr, M.D., proposed that Plaintiff Ms. Dohallow undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

242. Dr. Ryan Carr, M.D. performed the left hip total arthroplasty surgery at Porter Adventist Hospital on August 5, 2016 without apparent complication.

243. After her surgery, Plaintiff Ms. Dohallow received a letter from Porter Adventist Hospital in April of 2018 notifying her of potential exposure to blood-borne pathogens due to sterilization breaches at Porter Adventist Hospital.

244. The results from cultures taken from Plaintiff Ms. Dohallow's blood testing dated May 1, 2018 demonstrated an active Hepatitis C infection.

245. Ms. Doshallow's treating physicians determined she had been at low risk for contracting Hepatitis C and concluded she contracted Hepatitis C from Porter Adventist Hospital.

246. As a result of Plaintiff Ms. Dohallow's Hepatitis C infection, she required medications and treatment, as well as caused Plaintiff Ms. Dohallow to suffer associated economic and noneconomic damages.

247. At all times relevant, Plaintiff Ms. Dohallow was married to her spouse, Plaintiff James Neil.

248. Plaintiff Ms. Dohallow's surgical site infection caused her spouse, Plaintiff James Neil, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

7. Plaintiff Shawn Hand's surgical site infection of August 8, 2016

249. Plaintiff Shawn Hand ("Mr. Hand") was scheduled for aortic valve replacement surgery and his surgeon, Dr. Myles S. Guber, M.D., proposed that Plaintiff Mr. Hand undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

250. Dr. Myles S. Guber, M.D. performed the aortic valve replacement surgery at Porter Adventist Hospital on August 8, 2016 without apparent complication.

251. On November 23, 2016, Plaintiff Mr. Hand went to the Sky Ridge Medical Center emergency room complaining of generalized weakness, fatigue, and shortness of breath since his surgery, whereupon he was diagnosed with bacterial endocarditis.

252. The results from cultures taken from Plaintiff Mr. Hand's surgical site diagnosed Plaintiff Mr. Hand with a surgical site infection pathogen of Propionibacterium acnes bacteria.

253. As a result of Plaintiff Mr. Hand's Propionibacterium acnes infection, he required additional hospitalizations for medical complications, other procedures, and antibiotics, as well as caused Plaintiff Mr. Hand to suffer associated economic and noneconomic damages.

8. Plaintiff Kevin Dickes' surgical site infection of August 31, 2016

254. Plaintiff Kevin Dickes ("Mr. Dickes") was scheduled for total hip arthroplasty surgery and his surgeon, Dr. Charlie Yang, M.D., proposed that Plaintiff Mr. Dickes undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

255. Dr. Charlie Yang, M.D. performed the total hip arthroplasty surgery at Porter Adventist Hospital on August 31, 2016 without apparent complication.

256. After his surgery, Plaintiff Mr. Dickes began to experience left hip pain, nausea, fevers, erythema around the wound, and purulent drainage from the surgical site, such that Dr. Jason Jennings, M.D. performed an irrigation and debridement.

257. The results from cultures taken from Plaintiff Mr. Dickes' surgical site diagnosed Plaintiff Mr. Dickes with a surgical site infection pathogen of Methicillin-sensitive Staphylococcus aureus.

258. As a result of Plaintiff Mr. Dickes' Methicillin-sensitive Staphylococcus aureus infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Dickes to suffer associated economic and noneconomic damages.

9. Plaintiff Jacqueline Armstrong's surgical site infection of September 7, 2016

259. Plaintiff Jacqueline Armstrong ("Ms. Armstrong") was scheduled for L1, L3, L4 bilateral semi-hemi laminectomy with foraminotomies surgery and her surgeon, Dr. Sean Markey, M.D., proposed that Plaintiff Ms. Armstrong undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

260. Dr. Sean Markey, M.D. performed the L1, L3, L4 bilateral semi-hemi laminectomy with foraminotomies surgery at Porter Adventist Hospital on June 11, 2016 without apparent complication.

261. After her surgery, Plaintiff Ms. Armstrong began to experience severe back pain, fever, and drainage from her surgical wound, such that Dr. Sean Markey, M.D. performed a drainage of the surgical site wound, debridement of necrotic tissues, and repair of the durotomy with a fat graft.

262. The results from cultures taken from Plaintiff Ms. Armstrong's surgical site diagnosed Plaintiff Ms. Armstrong with a surgical site infection pathogen of Klebsiella pneumoniae.

263. As a result of Plaintiff Ms. Armstrong's Klebsiella pneumoniae infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Armstrong to suffer associated economic and noneconomic damages.

264. At all times relevant, Plaintiff Ms. Armstrong was married to her spouse, Plaintiff Joseph Armstrong.

265. Plaintiff Ms. Armstrong's surgical site infection caused her spouse, Plaintiff Joseph Armstrong, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

10. Plaintiff Dennis Groven's surgical site infection of <u>September 12, 2016</u>

266. Plaintiff Dennis Groven ("Mr. Groven") was scheduled for left olecranon bursectomy surgery and his surgeon, Dr. Craig Turner, M.D., proposed that Plaintiff Mr. Groven undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

267. Dr. Craig Turner, M.D. performed the left olecranon bursectomy surgery at Porter Adventist Hospital on September 12, 2016 without apparent complication.

268. After his surgery, Plaintiff Mr. Groven began to experience purulent drainage from his surgical site wound, such that Dr. Craig Turner, M.D. performed left olecranon bursectomy surgery on May 2, 2018.

269. The results from cultures taken from Plaintiff Mr. Groven's surgical site diagnosed Plaintiff Mr. Groven with an infection of unconfirmed pathogen.

270. As a result of Plaintiff Mr. Groven's unconfirmed pathogen infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Groven to suffer associated economic and noneconomic damages.

271. At all times relevant, Plaintiff Mr. Groven was married to his spouse, Plaintiff Shelly Groven.

272. Plaintiff Mr. Groven's surgical site infection caused his spouse, Plaintiff Shelly Groven, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

11. Plaintiff Richard Stotler's surgical site infection of September 14, 2016

273. Plaintiff Richard Stotler ("Mr. Stotler") was scheduled for lumbar decompression surgery and his surgeon, Dr. Sean Markey, M.D., proposed that Plaintiff Mr. Stotler undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

274. Dr. Sean Markey, M.D. performed the lumbar decompression surgery at Porter Adventist Hospital on September 14, 2016 without apparent complication.

275. After his surgery, Plaintiff Mr. Stotler began to experience postoperative weakness in both legs, bilateral foot numbness, and a fever, such that Dr. Sean Markey, M.D. performed an irrigation and debridement on September 29, 2016.

276. The results from cultures taken from Plaintiff Mr. Stotler's surgical site diagnosed Plaintiff Mr. Stotler with a surgical site infection pathogen of Escherichia coli.

277. As a result of Plaintiff Mr. Stotler's Escherichia coli infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Stotler to suffer associated economic and noneconomic damages.

12. Plaintiff Sarah Cline-Lebsack's surgical site infection of September 19, 2016

278. Plaintiff Sarah Cline-Lebsack ("Ms. Cline-Lebsack") was scheduled for total right hip arthroplasty surgery and her surgeon, Dr. Brian White, M.D., proposed that Plaintiff Ms. Armstrong undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

279. Dr. Brian White, M.D. performed the total right hip arthroplasty surgery at Porter Adventist Hospital on September 19, 2016 without apparent complication.

280. After her surgery, Plaintiff Ms. Cline-Lebsack began to experience a hematoma and pain around her surgical wound, such that Dr. Brian White, M.D. performed an irrigation and debridement on December 8, 2016 and December 23, 2016.

281. The results from cultures taken from Plaintiff Ms. Cline-Lebsack's surgical site diagnosed Plaintiff Ms. Cline-Lebsack with a surgical site infection pathogens of Klebsiella pneumoniae and Propionibacterium acnes.

282. As a result of Plaintiff Ms. Cline-Lebsack's Klebsiella pneumoniae and Propionibacterium acnes infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Cline-Lebsack to suffer associated economic and noneconomic damages.

283. At all times relevant, Plaintiff Ms. Cline-Lebsack was married to her spouse, Plaintiff David Cline-Lebsack.

284. Plaintiff Ms. Cline-Lebsack's surgical site infection caused her spouse, Plaintiff David Cline-Lebsack, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

13. Plaintiff Tammie Welch's surgical site infection of September 21, 2016

285. Plaintiff Tammie Welch ("Ms. Welch") was scheduled for right ankle arthrotomy and mass excision surgery and her surgeon, Dr. Edward Raczka, D.P.M., proposed that Plaintiff Ms. Welch undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

286. Dr. Edward Raczka, D.P.M. performed the total right hip arthroplasty surgery at Porter Adventist Hospital on September 21, 2016 without apparent complication.

287. After her surgery, Plaintiff Ms. Welch began to experience erythema and pain around her surgical wound, such that Dr. Edward Raczka, D.P.M. performed an irrigation and debridement on November 4, 2016.

288. The results from cultures taken from Plaintiff Ms. Welch's surgical site diagnosed Plaintiff Ms. Welch with surgical site infection pathogens of Pseudomonas Fleuorescens and Coagulase-negative staphylococci.

289. As a result of Plaintiff Ms. Welch's Pseudomonas Fleuorescens and Coagulase-negative staphylococci infections, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Welch to suffer associated economic and noneconomic damages.

14. Plaintiff Debbie Schulze's surgical site infection of September 22, 2016

290. Plaintiff Debbie Schulze ("Ms. Schulze") was scheduled for total right hip arthroplasty surgery and her surgeon, Dr. Todd Miner, M.D., proposed that Plaintiff Ms. Schulze undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

291. Dr. Todd Miner, M.D. performed the total right hip arthroplasty surgery at Porter Adventist Hospital on September 22, 2016 without apparent complication.

292. After her surgery, Plaintiff Ms. Schulze began to experience hip pain, a follicular type of erythematous rash around the incision and wound drainage, such that Dr. Todd Miner, M.D. performed an irrigation and debridement on December 28, 2016.

293. The results from cultures taken from Plaintiff Ms. Schulze's surgical site did not confirm a specific pathogen.

294. As a result of Plaintiff Ms. Schulze's undiagnosed pathogen infection, she required additional hospitalizations for medical complications, surgery and other procedures, and

antibiotics, as well as caused Plaintiff Ms. Schulze to suffer associated economic and noneconomic damages.

295. At all times relevant, Plaintiff Ms. Schulze was married to her spouse, Plaintiff Jon Schulze.

296. Plaintiff Ms. Schulze's surgical site infection caused her spouse, Plaintiff Jon Schulze, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

15. *Plaintiff Angila Lewandowski's surgical site infection of October 10, 2016*

297. Plaintiff Angila Lewandowski ("Ms. Lewandowski") was scheduled for double mastectomy and breast reconstruction and her surgeons, Dr. Caitlyn Truong, M.D. and Dr. Conrad Tirre, M.D., proposed that Plaintiff Ms. Lewandowski undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

298. Dr. Caitlyn Truong, M.D. and Dr. Conrad Tirre, M.D. performed the double mastectomy and breast reconstruction at Porter Adventist Hospital on October 10, 2016 without apparent complication.

299. After her surgery, Plaintiff Ms. Lewandowski began to experience erythema and cellulitis on her right breast, such that Dr. Conrad Tirre, M.D. performed an irrigation and debridement on November 19, 2016.

300. After her irrigation and debridement surgery on the right breast, Plaintiff Ms. Lewandowski began to experience erythema and cellulitis on her left breast, such that Dr. Conrad Tirre, M.D. performed an irrigation and debridement on December 29, 2016.

301. The results from cultures taken from Plaintiff Ms. Lewandowski's surgical sites diagnosed Ms. Lewandowski with a surgical site infection pathogen of Scedosporium apiospermum.

302. As a result of Plaintiff Ms. Lewandowski's Scedosporium apiospermum infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Lewandowski to suffer associated economic and noneconomic damages.

16. *Plaintiff Carol Murphy's surgical site infection of October 10, 2016*

303. Plaintiff Carol Murphy ("Ms. Murphy") was scheduled for right hip arthroplasty revision and her surgeon, Dr. Charlie Yang, M.D. proposed that Plaintiff Ms. Murphy undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

304. Dr. Charlie Yang, M.D. performed the right hip arthroplasty revision at Porter Adventist Hospital on October 10, 2016 without apparent complication.

305. After her surgery, Plaintiff Ms. Murphy began to experience fever, a hematoma, and erythema and redness at the surgical site, such that Dr. Richard Rutherford, M.D. performed an irrigation and debridement on November 4, 2016.

306. Plaintiff Ms. Murphy's infection symptoms returned after she completed her prescribed antibiotics, and Dr. Charlie Yang, M.D. performed an excision right hip arthroplasty with antibiotic spacers placement on June 28, 2017.

307. The results from cultures taken from Plaintiff Ms. Murphy's surgical sites diagnosed Ms. Murphy with a surgical site infection pathogen of Methicillin-resistant Staphylococcus aureus.

308. As a result of Plaintiff Murphy's Methicillin-resistant Staphylococcus aureus infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Murphy to suffer associated economic and noneconomic damages.

17. Plaintiff Kacey Craig's surgical site infection of October 10, 2016

309. Plaintiff Kacey Craig ("Ms. Craig") was scheduled for femoral osteoplasty and arthroscopy surgery and her surgeons, Dr. Brian White, M.D. and Dr. Ronald Hugate, M.D., proposed that Plaintiff Ms. Craig undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

310. Dr. Brian White, M.D. and Dr. Ronald Hugate, M.D. performed the femoral osteoplasty and arthroscopy surgery at Porter Adventist Hospital on October 10, 2016 without apparent complication.

311. After her surgery, Plaintiff Ms. Craig began to experience drainage from her surgical incision, such that Dr. Ronald Hugate, M.D. recommended she take oral antibiotics.

312. The results from cultures taken from Plaintiff Ms. Craig did not confirm a specific pathogen.

313. As a result of Plaintiff Ms. Craig's undiagnosed pathogen infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Craig to suffer associated economic and noneconomic damages.

314. At all times relevant, Plaintiff Ms. Craig was married to her spouse, Plaintiff Jesse Craig.

315. Plaintiff Ms. Craig's surgical site infection caused her spouse, Plaintiff Jesse Craig, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

18. Plaintiff Brett Siegrist's surgical site infection of November 21, 2016

316. Plaintiff Brett Siegrist ("Mr. Siegrist") was scheduled for total right hip arthroplasty surgery and his surgeon, Dr. Douglas Dennis, M.D., proposed that Plaintiff Mr. Siegrist undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

317. Dr. Douglas Dennis, M.D. performed the total right hip arthroplasty surgery at Porter Adventist Hospital on November 21, 2016 without apparent complication.

318. After his surgery, Plaintiff Mr. Siegrist began to experience postoperative pain, such that Dr. Douglas Dennis, M.D. performed total hip revision arthroplasty with placement of antibiotic spacers, and an irrigation and debridement on July 19, 2017.

319. The results from cultures taken from Plaintiff Mr. Siegrist's surgical site diagnosed Plaintiff Mr. Siegrist with a surgical site infection pathogen of Propionibacterium acnes.

320. As a result of Plaintiff Mr. Siegrist's Propionibacterium acnes infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Siegrist to suffer associated economic and noneconomic damages.

19. Plaintiff Richard Knippelmeyer's surgical site infection of November 22, 2016

321. Plaintiff Richard Knippelmeyer ("Mr. Knippelmeyer") was scheduled for anterior left total hip arthroplasty surgery and his surgeon, Dr. Todd Miner, M.D., proposed that Plaintiff Mr. Knippelmeyer undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

322. Dr. Todd Miner, M.D. performed the anterior left total hip arthroplasty surgery at Porter Adventist Hospital on November 22, 2016 without apparent complication.

323. After his surgery, Plaintiff Mr. Knippelmeyer began to experience drainage of fluid from his surgical wound and swelling with redness around the surgical site, such that Dr. Todd Miner, M.D. performed an evacuation, irrigation and debridement, and repair of the deep wound dehiscence on Plaintiff Mr. Knippelmeyer's left hip on December 19, 2016.

324. The results from cultures taken from Plaintiff Mr. Knippelmeyer did not confirm a specific pathogen.

325. As a result of Plaintiff Mr. Knippelmeyer's undiagnosed pathogen infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Knippelmeyer to suffer associated economic and noneconomic damages.

326. At all times relevant, Plaintiff Mr. Knippelmeyer was married to his spouse, Plaintiff Connie Knippelmeyer.

327. Plaintiff Mr. Knippelmeyer's surgical site infection caused his spouse, Plaintiff Connie Knippelmeyer, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

20. Plaintiff Mohamed Ali Elmi's surgical site infection of December 19, 2016

328. Plaintiff Mohamed Almi Elmi ("Mr. Elmi") was scheduled for a left knee arthroscopic partial medial meniscectomy and anterior cruciate ligament repair surgery and his surgeon, Dr. Steven Kitchen, M.D., proposed that Plaintiff Mr. Elmi undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

329. Dr. Steven Kitchen, M.D. performed the left knee arthroscopic partial medial meniscectomy and anterior cruciate ligament repair surgery at Porter Adventist Hospital on December 19, 2016 without apparent complication.

330. After his surgery, Plaintiff Mr. Elmi began to experience pus and drainage from his surgical wound, such that Dr. Steven Kitchen, M.D. performed a clean out procedure.

331. The results from cultures taken from Plaintiff Mr. Elmi did not confirm a specific pathogen.

332. As a result of Plaintiff Mr. Elmi's undiagnosed pathogen infection, he required additional hospitalizations for medical complications, other procedures, and antibiotics, as well as caused Plaintiff Mr. Elmi to suffer associated economic and noneconomic damages.

21. *Plaintiff Kim Kane's surgical site infection of December 20, 2016*

333. Plaintiff Kim Kane ("Ms. Kane") was scheduled for left total hip replacement surgery and her surgeon, Dr. Brian White, M.D., proposed that Plaintiff Ms. Kane undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

334. Dr. Brian White, M.D. performed the left total hip replacement surgery at Porter Adventist Hospital on December 20, 2016 without apparent complication.

335. After her surgery, Plaintiff Ms. Kane began to experience chills, as well as redness and drainage from her surgical wound, such that Dr. Brian White, M.D. performed an irrigation and debridement on January 17, 2017.

336. The results from cultures taken from Plaintiff Ms. Kane's surgical sites diagnosed Ms. Kane with a surgical site infection pathogen of Methicillin-sensitive Staphylococcus aureus.

337. As a result of Plaintiff Ms. Kane's Methicillin-sensitive Staphylococcus aureus infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Kane to suffer associated economic and noneconomic damages.

22. *Plaintiff Lauren Morales' surgical site infection of January 23, 2017*

338. Plaintiff Lauren Morales ("Ms. Morales") was scheduled for T7-T8 laminectomy and spinal cord stimulator placement surgery and her surgeon, Dr. George Frey, M.D. proposed that Plaintiff Ms. Morales undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

339. Dr. George Frey, M.D. performed the T7-T8 laminectomy and spinal cord stimulator placement surgery at Porter Adventist Hospital on January 23, 2017 without apparent complication.

340. After her surgery, Plaintiff Ms. Morales began to experience purulent drainage from her surgical wound, such that she went to the emergency rooms at Colorado Plains Medical Center and Porter Adventist Hospital.

341. The results from cultures taken from Plaintiff Ms. Morales' surgical sites diagnosed Ms. Morales with a surgical site infection pathogen of Methicillin-sensitive Staphylococcus aureus.

342. As a result of Plaintiff Morales' Methicillin-sensitive Staphylococcus aureus infection, she required additional hospitalizations for medical complications, other procedures, and antibiotics, as well as caused Plaintiff Ms. Morales to suffer associated economic and noneconomic damages.

23. *Plaintiff Raelene Middlestadt's infection of January 24, 2017*

343. Plaintiff Raelene Middlestadt ("Ms. Middlestadt") was scheduled for T7-T8 C5-C6 and C6-C7 anterior cervical diskectomy and fusion surgery and her surgeon, Dr. Winston Capel, M.D. proposed that Plaintiff Ms. Middlestadt undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

344. Dr. Winston Capel, M.D. performed the T7-T8 laminectomy and spinal cord stimulator placement surgery at Porter Adventist Hospital on January 24, 2017 without apparent complication.

345. After her surgery, Plaintiff Ms. Middlestadt received a letter from Porter Adventist Hospital in April of 2018 notifying her of the potential exposure to blood-borne pathogens due to sterilization breaches at Porter Adventist Hospital.

346. The results from cultures taken from Plaintiff Ms. Middlestadt's blood testing dated May 16, 2018 demonstrated an active Hepatitis C infection and the pathogens for Hepatitis B.

347. Ms. Middlestadt's treating physicians determined she possibly contracted Hepatitis C from Porter Adventist Hospital.

348. As a result of Plaintiff Ms. Middlestadt's Hepatitis C infection, she required medications and treatment, as well as caused Plaintiff Ms. Middlestadt to suffer associated economic and noneconomic damages.

24. Plaintiff Karen Lund's surgical site infection of February 6, 2017

349. Plaintiff Karen Lund ("Ms. Lund") was scheduled for right total hip revision arthroplasty surgery and her surgeon, Dr. Charlie Yang, M.D., proposed that Plaintiff Ms. Lund undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

350. Dr. Charlie Yang, M.D. performed the right total hip revision arthroplasty surgery at Porter Adventist Hospital on February 6, 2017 using sterile technique and without apparent complication.

351. In the months following her surgery, Plaintiff Ms. Lund experienced signs and symptoms of an infection, including elevated C-reactive protein in her bloodwork and a collection of fluid around her surgical site wound. She was diagnosed with a hematoma, which eventually subsided until February 2019 when she developed swelling, redness, and pain associated with fevers, chills and fatigue.

352. An aspiration of the fluid in her hip confirmed the presence of a severe infection, Enterococcus, in her hip joint. On February 21, 2019 Dr. Greenhow performed hip surgery to eradicate the infection, including replacement of implanted prosthetic devices, with irrigation and debridement surgery. She was placed on a PICC-line regimen of antibiotics for 8 weeks, and then continued with oral antibiotics.

353. As a result of Plaintiff Ms. Lund's infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Lund to suffer associated economic and noneconomic damages.

354. At all times relevant, Plaintiff Ms. Lund was married to her spouse, Plaintiff Robert Lund.

355. Plaintiff Ms. Lund's surgical site infection caused her spouse, Plaintiff Robert Lund, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

25. Plaintiff Kathryn Hanson's surgical site infection of February 6, 2017

356. Plaintiff Kathryn Hanson ("Ms. Hanson") was scheduled for right total hip arthroplasty surgery and her surgeons, Dr. Brian White, M.D., proposed that Plaintiff Ms. Hanson undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

357. Dr. Brian White, M.D. performed the right total hip arthroplasty surgery at Porter Adventist Hospital on February 6, 2017 without apparent complication.

358. After her surgery, Plaintiff Ms. Hanson began to experience swelling, drainage, and a hematoma at her surgical site, such that Dr. Brian White, M.D. performed a wash out of the hematoma and ultrasound-guided percutaneous aspiration on February 15, 2017.

359. The results from cultures taken from Plaintiff Ms. Hanson' surgical sites diagnosed Ms. Hanson with a surgical site infection pathogen of Clostridium difficile.

360. As a result of Plaintiff Ms. Hanson's Clostridium difficile, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Hanson to suffer associated economic and noneconomic damages.

361. At all times relevant, Plaintiff Ms. Hanson was married to her spouse, Plaintiff James Hanson.

362. Plaintiff Ms. Hanson's surgical site infection caused her spouse, Plaintiff James Hanson, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

26. Plaintiff Kevin Alley's surgical site infection of February 17, 2017

363. Plaintiff Kevin Alley ("Mr. Alley") was scheduled for right knee total arthroplasty surgery and his surgeon, Dr. Jason Jennings, M.D., proposed that Plaintiff Mr. Alley undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

364. Dr. Jason Jennings, M.D. performed the right knee total arthroplasty surgery at Porter Adventist Hospital on February 17, 2017 without apparent complication.

365. After her surgery, Plaintiff Mr. Alley received a letter from Porter Adventist Hospital in April of 2018 notifying him of potential exposure to blood-borne pathogens due to sterilization breaches at Porter Adventist Hospital.

366. The results from cultures taken from Plaintiff Alley's blood testing demonstrated an active Hepatitis C infection.

367. As a result of Plaintiff Mr. Alley's Hepatitis C infection, he required medications and treatment, as well as caused Plaintiff Mr. Alley to suffer associated economic and noneconomic damages.

27. Plaintiff Jerry Owen's surgical site infection of February 23, 2017

368. Plaintiff Jerry Owen ("Mr. Owen") was scheduled for cervical fusion and diskectomy surgery and his surgeon, Dr. Sean Markey, M.D., proposed that Plaintiff Mr. Owen undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

369. Dr. Sean Markey, M.D. performed the cervical fusion and diskectomy surgery at Porter Adventist Hospital on February 23, 2017 without apparent complication.

370. After his surgery, Plaintiff Mr. Owen began to experience non-closure and dehiscence of the surgical site, such that Dr. Sean Markey, M.D. performed a wound closure on March 23, 2017.

371. The results from cultures taken from Plaintiff Mr. Owen's surgical site diagnosed Plaintiff Mr. Owen with a surgical site infection pathogen of Enterococcus faecalis.

372. As a result of Plaintiff Mr. Owen's Enterococcus faecalis infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Owen to suffer associated economic and noneconomic damages.

28. Plaintiff Jonathan Colbeth's surgical site infection of March 1, 2017

373. Plaintiff Jonathan Colbeth ("Mr. Colbeth") was scheduled for left total hip arthroplasty surgery and his surgeon, Dr. Ryan Carr, M.D., proposed that Plaintiff Mr. Colbeth undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

374. Dr. Ryan Carr, M.D. performed the left total hip arthroplasty surgery at Porter Adventist Hospital on March 1, 2017 without apparent complication.

375. After his surgery, Plaintiff Mr. Colbeth began to experience fatigue, fever, and delusions such that he reported to the emergency room at St. Anthony's Hospital North, whereupon he was transferred to Porter Adventist Hospital due to a suspected surgical site infection.

376. On May 17, 2017, Dr. Ryan Carr, M.D. performed a removal of hardware with an irrigation and debridement due to Mr. Colbeth's surgical site infection.

377. The results from cultures taken from Plaintiff Mr. Colbeth's surgical site diagnosed Plaintiff Mr. Colbeth with a surgical site infection pathogen of Group B streptococcus.

378. As a result of Plaintiff Mr. Colbeth's Group B streptococcus infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Colbeth to suffer associated economic and noneconomic damages.

29. Plaintiff Michelle Coleman's surgical site infection of March 7, 2017

379. Plaintiff Michelle Coleman ("Ms. Coleman") was scheduled for cervical fusion surgery and her surgeon, Dr. Sean Markey, M.D., proposed that Plaintiff Ms. Coleman undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

380. Dr. Sean Markey, M.D. performed the cervical fusion surgery at Porter Adventist Hospital on March 7, 2017 without apparent complication.

381. After her surgery, Plaintiff Ms. Coleman began to experience pain and opening of her surgical site wound with drainage, such that Dr. Sean Markey, M.D. performed a closure of the wound with an irrigation and debridement on April 17, 2017.

382. The results from cultures taken from Plaintiff Ms. Coleman's surgical site diagnosed Plaintiff Ms. Coleman with a surgical site infection pathogen of rare Methicillin-resistant Staphylococcus aureus.

383. As a result of Plaintiff Ms. Coleman's rare Methicillin-resistant Staphylococcus aureus infection, she required additional hospitalizations for medical complications, surgery and other

procedures, and antibiotics, as well as caused Plaintiff Ms. Coleman to suffer associated economic and noneconomic damages.

30. Plaintiff Carmelita Carrillo's surgical site infection of March 8, 2017

384. Plaintiff Carmelita Carrillo ("Ms. Carrillo") was scheduled for Chiari malformation decompression surgery and her surgeon, Dr. Sean Markey, M.D., proposed that Plaintiff Ms. Carrillo undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

385. Dr. Sean Markey, M.D. performed the Chiari malformation decompression surgery at Porter Adventist Hospital on March 8, 2017 without apparent complication.

386. After her surgery, Plaintiff Ms. Carrillo began to experience drainage from her surgical site wound, slurred speech, headaches, blurred vision, facial twitching, and balance issues, such that Dr. John Oro, M.D. performed an excision of a purulent area under her cervical wound and extension of her laminectomy and craniectomy surgery on October 24, 2017.

387. The results from cultures taken from Plaintiff Ms. Carrillo's purulent area in her surgical wound diagnosed Plaintiff Ms. Carrillo with an unconfirmed pathogen.

388. As a result of Plaintiff Ms. Carrillo's unconfirmed pathogen infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Carrillo to suffer associated economic and noneconomic damages.

31. Plaintiff Betty Wriston's husband's surgical site infection of March 9, 2017

389. At all times material hereto, Plaintiff Mrs. Wriston was married to Thomas Wriston, deceased.

390. Thomas Wriston ("Mr. Wriston") was born on September 2, 1938 and died on June 25, 2017.

391. Mr. Wriston fell on March 9, 2017 and fractured his femur and right hip.

392. Mr. Wriston was transported to St. Anthony Summit Medical Center for evaluation of his femur and hip fractures.

393. After being evaluated at St. Anthony Summit Medical Center, Mr. Wriston requested he be transferred to Porter Adventist Hospital for a necessary surgery of internal fixation of his periprosthetic femur fracture because of prior successful surgeries at Porter Adventist Hospital.

394. Dr. Jason Jennings, M.D. performed the femur open reduction internal fixation surgery on Mr. Wriston at Porter Adventist Hospital on March 9, 2017 without apparent complication.

395. After his surgery, Mr. Winston began to develop a cough and a fever, such that on May 12, 2017, Mr. Wriston presented to the emergency room at St. Anthony Summit Medical Center via ambulance with severe sepsis and pneumonia.

396. On May 18, 2017, Mr. Wriston was evaluated by physicians at Penrose Hospital who diagnosed him with a Propionibacterium acnes infection.

397. Mr. Wriston's physicians at Penrose Hospital noted "given timeline of his presentation, [we] would be worried about hardware and surgical site infection of the right hip . . . ."

398. Due to Mr. Wriston's severe sepsis, respiratory failure, pneumonia, anemia, and subacute kidney injury, he passed away on June 25, 2017.

399. As a result of Mr. Wriston's Propionibacterium acnes infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Mr. Wriston to suffer associated economic and noneconomic damages, including his untimely death.

400. Mr. Wriston's surgical site infection caused his spouse, Plaintiff Betty Wriston, to suffer damages associated with the wrongful death of her husband.

32. Plaintiff Mary Goyette's surgical site infection of April 14, 2017

401. Plaintiff Mary Goyette ("Ms. Goyette") was scheduled for bunionectomy surgery and her surgeon, Dr. Edward Raczka, D.P.M., proposed that Plaintiff Ms. Goyette undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

402. Dr. Edward Raczka, D.P.M. performed the bunionectomy surgery at Porter Adventist Hospital on April 14, 2017, beginning at approximately 4:00 p.m., without apparent complication.

403. The April 14, 2017 was originally scheduled at 11:00 a.m., but was delayed for approximately five hours due to concerns about sterilization of devices to be used in the surgery.

404. After her surgery, Plaintiff Ms. Goyette began to experience redness and pain at her surgical site wound with pus drainage, such that Dr. Edward Raczka, D.P.M. performed a drainage with an irrigation and debridement surgery on June 28, 2017.

405. The results from cultures taken from Plaintiff Ms. Goyette's surgical site diagnosed Plaintiff Ms. Goyette with an infection of an undiagnosed pathogen.

406. As a result of Plaintiff Ms. Goyette's undiagnosed pathogen infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Goyette to suffer associated economic and noneconomic damages.

33. Plaintiff Anthony Marino's surgical site infection of April 19, 2017

407. Plaintiff Anthony Marino ("Mr. Marino") was scheduled for an irrigation and debridement of a wound seroma surgery and his surgeon, Dr. Sean Markey, M.D., proposed that Plaintiff Mr. Marino undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

408. Dr. Sean Markey, M.D. performed the irrigation and debridement of a wound seroma surgery at Porter Adventist Hospital on April 19, 2017 without apparent complication.

409. After his surgery, Plaintiff Mr. Marino began to experience drainage from his surgical site wound, such that Dr. Sean Markey, M.D. performed a wound closure with irrigation and debridement surgery on May 26, 2017.

410. The results from cultures taken from Plaintiff Mr. Marino's surgical site diagnosed Plaintiff Mr. Marino with a surgical site infection pathogen of Methicillin-resistant Staphylococcus aureus.

411. As a result of Plaintiff Mr. Marino's Methicillin-resistant Staphylococcus aureus infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Marino to suffer associated economic and noneconomic damages.

34. Plaintiff Luana Kurz's surgical site infection of April 20, 2017

412. Plaintiff Luana Kurz ("Ms. Kurz") was scheduled for arthroscopic labral reconstruction surgery and her surgeon, Dr. Brian White, M.D., proposed that Plaintiff Ms. Kurz undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

413. Dr. Brian White, M.D. performed the arthroscopic labral reconstruction surgery at Porter Adventist Hospital on April 20, 2017, without apparent complication.

414. Plaintiff Ms. Kurz was scheduled for periacetabular osteotomy surgery and her surgeon, Dr. Ronald Hugate, M.D., proposed that Plaintiff Ms. Kurz undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

415. Dr. Ronald Hugate, M.D. performed the periacetabular osteotomy surgery at Porter Adventist Hospital on May 8, 2017, without apparent complication.

416. After her surgery, Plaintiff Ms. Kurz began to experience discoloration of and drainage from her surgical site wound on her hip, such that Dr. Ronald Hugate, M.D. performed a removal of the hip hardware with irrigation and debridement surgery on September 20, 2017.

417. The results from cultures taken from Plaintiff Ms. Kurz's surgical site diagnosed Plaintiff Ms. Kurz with a surgical site infection of Pseudomonas aeruginosa.

418. As a result of Plaintiff Ms. Kurz's Pseudomonas aeruginosa infection, she required additional hospitalizations for medical complications, surgery and other procedures, and

antibiotics, as well as caused Plaintiff Ms. Kurz to suffer associated economic and noneconomic damages.

35. Plaintiff Joanne Stewart's surgical site infection of May 18, 2017

419. Plaintiff Joanne Stewart ("Ms. Stewart") was scheduled for right total hip arthroplasty surgery and her surgeons, Dr. Jason Jennings, M.D., proposed that Plaintiff Ms. Stewart undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

420. Dr. Jason Jennings, M.D. performed the right total hip arthroplasty surgery at Porter Adventist Hospital on May 18, 2017 without apparent complication.

421. Five days after her surgery, Plaintiff Ms. Stewart was found by a neighbor in an altered mental state, such that she was transported to Littleton Medical Center and she was tested for sepsis.

422. The results from cultures taken from Plaintiff Ms. Stewart diagnosed Ms. Stewart with an infection pathogen of Clostridium difficile.

423. As a result of Plaintiff Ms. Stewart's Clostridium difficile, she required additional hospitalizations for medical complications, other procedures, and antibiotics, as well as caused Plaintiff Ms. Stewart to suffer associated economic and noneconomic damages.

36. Plaintiff Rebecca Brown's surgical site infection of June 1, 2017

424. Plaintiff Rebecca Brown ("Ms. Brown") was scheduled for lumbar fusion and her surgeon, Dr. Sean Markey, M.D., proposed that Plaintiff Ms. Brown undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

425. Dr. Sean Markey, M.D. performed the lumbar fusion surgery at Porter Adventist Hospital on June 1, 2017 without apparent complication.

426. After her surgery, Plaintiff Ms. Brown began to experience fever, nausea, malaise, and weakness and she was diagnosed with severe sepsis.

427. The results from cultures diagnosed Plaintiff Ms. Brown with a Clostridium difficile infection.

428. As a result of Plaintiff Ms. Brown's Clostridium difficile, she required additional hospitalizations for medical complications, antibiotics, and caused Plaintiff Ms. Brown to suffer associated economic and noneconomic damages.

37. Plaintiff Jeanne Meardon's surgical site infection of June 8, 2017

429. Plaintiff Jeanne Meardon ("Ms. Meardon") was scheduled for thoracic fusion surgery and her surgeon, Dr. Peter Syre, M.D., proposed that Plaintiff Ms. Meardon undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

430. Dr. Peter Syre, M.D. performed the thoracic fusion surgery at Porter Adventist Hospital on June 8, 2017 without apparent complication.

431. After her surgery, Plaintiff Ms. Meardon went into septic shock and was admitted to Sky Ridge Medical Center's emergency room on December 27, 2017 where an irrigation and debridement surgery on her shoulder was performed on December 28, 2017.

432. The results from cultures taken from Plaintiff Ms. Meardon diagnosed Plaintiff Ms. Meardon with a blood stream infection pathogen of Staphylococcus aureus.

433. As a result of Plaintiff Ms. Meardon's Staphylococcus aureus infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Meardon to suffer associated economic and noneconomic damages.

434. At all times relevant, Plaintiff Ms. Coleman was married to her spouse, Plaintiff Aaron Coleman.

435. Plaintiff Ms. Coleman's surgical site infection caused her spouse, Plaintiff Aaron Coleman, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

38. Plaintiff Brett Martinez's infection of June 15, 2017

436. Plaintiff Brett Martinez ("Mr. Martinez") was scheduled for a right patello-femoral arthroplasty surgery and his surgeon, Dr. Jason Jennings, M.D., proposed that Plaintiff Mr. Martinez undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

437. Dr. Jason Jennings, M.D. performed the right patello-femoral arthroplasty surgery at Porter Adventist Hospital on June 15, 2017 without apparent complication.

438. After his surgery, Plaintiff Mr. Martinez received a letter from Porter Adventist Hospital in April of 2018 notifying him of the potential exposure to blood-borne pathogens due to sterilization breaches at Porter Adventist Hospital.

439. The results from cultures taken from Plaintiff Mr. Martinez's blood testing dated April 10, 2018 demonstrated an active Hepatitis B infection.

440. As a result of Plaintiff Mr. Martinez's Hepatitis B infection, he required medications and treatment, as well as caused Plaintiff Mr. Martinez to suffer associated economic and noneconomic damages.

39. Plaintiff Kenneth Lutz's surgical site infection of June 27, 2017

441. Plaintiff Kenneth Lutz ("Mr. Lutz") was scheduled for right knee total arthroplasty surgery and his surgeon, Dr. Jason Jennings, M.D., proposed that Plaintiff Mr. Lutz undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

442. Dr. Jason Jennings, M.D. performed the right knee total arthroplasty surgery at Porter Adventist Hospital on June 27, 2017 without apparent complication.

443. After his surgery, Plaintiff Mr. Lutz began to experience a fever, with redness, swelling, and pain originating from his surgical site, such that Dr. Jason Jennings, M.D. performed a right knee total arthroplasty revision with irrigation and debridement surgery on August 9, 2018.

444. The results from cultures taken from Plaintiff Mr. Lutz's surgical site diagnosed Plaintiff Mr. Lutz with a surgical site infection of an undiagnosed pathogen.

445. As a result of Plaintiff Mr. Lutz's undiagnosed pathogen infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Lutz to suffer associated economic and noneconomic damages.

40. Plaintiff Janelle Favuzza's surgical site infection of July 10, 2017

446. Plaintiff Janelle Favuzza ("Ms. Favuzza") was scheduled for left sacroiliac joint fusion surgery and her surgeon, Dr. Winston Capel, M.D., proposed that Plaintiff Ms. Favuzza undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

447. Dr. Winston Capel, M.D. performed the left sacroiliac joint fusion surgery at Porter Adventist Hospital on July 10, 2017 without apparent complication.

448. After her surgery, Plaintiff Ms. Favuzza began to experience a fever, wound dehiscence, and drainage originating from her surgical site wound, such that Dr. James Neid, M.D. placed her on PICC line antibiotics.

449. The results from cultures taken from Plaintiff Ms. Favuzza's surgical site could not diagnose a specific pathogen.

450. As a result of Plaintiff Ms. Favuzza's undiagnosed pathogen infection, she required additional hospitalizations for medical complications, other procedures, and antibiotics, as well as caused Plaintiff Ms. Favuzza to suffer associated economic and noneconomic damages.

41. Plaintiff Lisa Edelen's surgical site infection of July 17, 2017

451. Plaintiff Lisa Edelen ("Ms. Edelen") was scheduled for lumbar fusion surgery and her surgeon, Dr. Michael Gallizzi, M.D., proposed that Plaintiff Ms. Edelen undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

452. Dr. Michael Gallizzi, M.D. performed the lumbar fusion surgery at Porter Adventist Hospital on July 17, 2017 without apparent complication.

453. After her surgery, Plaintiff Ms. Edelen began to experience drainage from her surgical site wound, such that she received an irrigation and debridement surgery at St. Joseph's hospital on December 6, 2017.

454. The results from cultures taken from Plaintiff Ms. Edelen diagnosed Plaintiff Ms. Edelen with an infection of an unknown pathogen.

455. As a result of Plaintiff unknown pathogen infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Edelen to suffer associated economic and noneconomic damages.

42. Plaintiff Mary Dyer's surgical site infection of July 26, 2017

456. Plaintiff Mary Dyer ("Ms. Dyer") was scheduled for acetabular revision of right total hip arthroplasty surgery and her surgeon, Dr. Todd Miner, M.D., proposed that Plaintiff Ms. Dyer undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

457. Dr. Todd Miner, M.D. performed the acetabular revision of right total hip arthroplasty surgery at Porter Adventist Hospital on July 26, 2017 without apparent complication.

458. After her surgery, Plaintiff Ms. Dyer began to experience fevers, pain, swelling, and drainage from her surgical site wound, such that Dr. Todd Miner, M.D. performed a right hip arthrotomy with irrigation and debridement surgeries on October 6, 2017 and October 18, 2017.

459. The results from cultures taken from Plaintiff Ms. Dyer diagnosed Plaintiff Ms. Dyer with a blood stream infection pathogen of Rare Streptococcus agalactiae (Group B).

460. As a result of Plaintiff Ms. Dyer's Rare Streptococcus agalactiae (Group B) infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Dyer to suffer associated economic and noneconomic damages.

43. Plaintiff Nicholas Bakarich's surgical site infection of August 7, 2017

461. Plaintiff Nicholas Bakarich ("Mr. Bakarich") was scheduled for right total hip arthroplasty surgery and his surgeon, Dr. Brian White, M.D., proposed that Plaintiff Mr. Bakarich undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

462. Dr. Brian White, M.D. performed the right total hip arthroplasty surgery at Porter Adventist Hospital on August 7, 2017 without apparent complication.

463. After his surgery, Plaintiff Mr. Bakarich began to experience a fever, wound erythema, and drainage from his surgical site, such that Dr. Brian White, M.D. performed an irrigation and debridement surgery on September 7, 2017.

464. The results from cultures taken from Plaintiff Mr. Bakarich's surgical site diagnosed Plaintiff Mr. Bakarich with a surgical site infection of Methicillin-sensitive Staphylococcus aureus.

465. As a result of Plaintiff Mr. Bakarich's Methicillin-sensitive Staphylococcus aureus infection, he required additional hospitalizations for medical complications, surgery and other

procedures, and antibiotics, as well as caused Plaintiff Mr. Bakarich to suffer associated economic and noneconomic damages.

466. At all times relevant, Plaintiff Mr. Bakarich was married to his spouse, Plaintiff Deborah Bakarich.

467. Plaintiff Mr. Bakarich's surgical site infection caused his spouse, Plaintiff Deborah Bakarich, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

44. Plaintiff Mary Robinson's surgical site infection of August 25, 2017

468. Plaintiff Mary Robinson ("Ms. Robinson") was scheduled for osteochondral fracture debridement surgery and her surgeon, Dr. Edward Raczka, D.P.M., proposed that Plaintiff Ms. Robinson undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

469. Dr. Edward Raczka, D.P.M. performed the osteochondral fracture debridement surgery at Porter Adventist Hospital on August 25, 2017 without apparent complication.

470. After her surgery, Plaintiff Ms. Robinson began to experience edema at her surgical site, such that Dr. Edward Raczka, D.P.M. performed a debridement procedure on September 12, 2017 without taking any cultures.

471. Subsequently, Plaintiff Ms. Robinson began to experience drainage from her surgical site wound, such that Dr. Edward Raczka, D.P.M. performed a drainage surgery on October 17, 2017.

472. The results from cultures taken from Plaintiff Ms. Robinson's surgical site diagnosed Plaintiff Ms. Robinson with a surgical site infection pathogens of Methicillin-resistant Staphylococcus aureus and Clostridium perfringens.

473. As a result of Plaintiff Ms. Robinson's Methicillin-resistant Staphylococcus aureus and Clostridium perfringens infections, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Robinson to suffer associated economic and noneconomic damages.

45. Plaintiff Gary Esch's surgical site infection of September 27, 2017

474. Plaintiff Gary Esch ("Mr. Esch") was scheduled for lumbar laminectomy and fusion surgery and his surgeon, Dr. Sean Markey, M.D., proposed that Plaintiff Mr. Esch undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

475. Dr. Sean Markey, M.D. performed the lumbar laminectomy and fusion surgery at Porter Adventist Hospital on September 27, 2017 without apparent complication.

476. After his surgery, Plaintiff Mr. Esch began to experience drainage from his surgical site wound, such that Dr. Sean Markey, M.D. performed an evacuation of a hematoma with an irrigation and debridement on October 11, 2017.

477. The results from cultures taken from Plaintiff Mr. Esch's surgical site diagnosed Plaintiff Mr. Esch with surgical site infection pathogens of Enterobacter cloacae and Klebsiella pneumoniae.

478. As a result of Plaintiff Mr. Esch's Enterobacter cloacae and Klebsiella pneumoniae infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Esch to suffer associated economic and noneconomic damages.

46. Plaintiff Leanne Priday's infection of October 9, 2017

479. Plaintiff Leanne Priday ("Ms. Priday") was scheduled for right total hip arthroplasty surgery and her surgeon, Dr. Charlie Yang, M.D., proposed that Plaintiff Ms. Priday undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

480. Dr. Charlie Yang, M.D. performed the right total hip arthroplasty surgery at Porter Adventist Hospital on October 9, 2017 without apparent complication.

481. After her surgery, Plaintiff Ms. Priday began to experience pain, headaches, and fevers, such that she was admitted to the hospital for four days at Porter Adventist Hospital and received a lumbar puncture on October 13, 2017.

482. While admitted to the hospital, Plaintiff Ms. Priday was diagnosed with viral meningitis.

483. As a result of Plaintiff Ms. Priday's viral meningitis infection, she required additional hospitalizations for medical complications, other procedures, and antibiotics, as well as caused Plaintiff Ms. Priday to suffer associated economic and noneconomic damages.

47. Plaintiff William Suarez's surgical site infection of October 12, 2017

484. Plaintiff William Suarez ("Mr. Suarez") was scheduled for complete revision left total knee arthroplasty surgery and his surgeon, Dr. Todd Miner, M.D., proposed that Plaintiff Mr. Suarez undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

485. Dr. Todd Miner, M.D. performed the complete revision left total knee arthroplasty surgery at Porter Adventist Hospital on October 12, 2017 without apparent complication.

486. After his surgery, Plaintiff Mr. Suarez began to experience pain and dehiscence of his surgical site wound, such that Dr. Conrad Tirre, M.D. performed a skin graft with an irrigation and debridement on November 3, 2017.

487. Due to the severity of the infection and amount of necrotic tissue, Mr. Suarez has undergone seven left knee surgeries to date.

488. The results from cultures taken from Plaintiff Mr. Suarez's surgical site diagnosed Plaintiff Mr. Suarez with surgical site infection pathogens of Hafnia alvei, Serratia, Enterococcus,

Escherichia coli, Group B streptococcus, Gram Positive Rod, and Methicillin-sensitive Staphylococcus aureus.

489. As a result of Plaintiff Mr. Suarez's Hafnia alvei, Serratia, Enterococcus, Escherichia coli, Group B streptococcus, Gram Positive Rod, and Methicillin-sensitive Staphylococcus aureus infections, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Suarez to suffer associated economic and noneconomic damages.

48. Plaintiff Trevor Williamson's surgical site infection of October 17, 2017

490. Plaintiff Trevor Williamson ("Mr. Williamson") was scheduled for L5-S1 foraminal laminotomy and diskectomy surgery and his surgeon, Dr. Sean Markey, M.D., proposed that Plaintiff Mr. Williamson undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

491. Dr. Sean Markey, M.D. performed the L5-S1 foraminal laminotomy and diskectomy surgery at Porter Adventist Hospital on October 17, 2017 without apparent complication.

492. After his surgery, Plaintiff Mr. Williamson began to experience pain and drainage from his surgical site wound, such that Dr. Sean Markey, M.D. performed a revision of the unilateral diskectomy L5-Sl and wound exploration surgery on December 14, 2017.

493. The results from cultures taken from Plaintiff Williamson's surgical site diagnosed Plaintiff Mr. Williamson with surgical site infection pathogens of Staphylococcus epidermidis, Staphylococcus lugdunensis, and Staphylococcus haemolyticus.

494. As a result of Plaintiff Mr. Williamson's Staphylococcus epidermidis, Staphylococcus lugdunensis, and Staphylococcus haemolyticus infections, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Williamson to suffer associated economic and noneconomic damages.

495. At all times relevant, Plaintiff Mr. Williamson was married to his spouse, Plaintiff Lori Williamson.

496. Plaintiff Mr. Williamson's surgical site infection caused his spouse, Plaintiff Lori Williamson, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

49. Plaintiff Darby Fish's infection of November 20, 2017

497. Plaintiff Darby Fish ("Mr. Fish") was scheduled for L3-S1 interbody fusion surgery and his surgeon, Dr. Peter Syre, M.D., proposed that Plaintiff Mr. Fish undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

498. Dr. Peter Syre, M.D. performed the L3-S1 interbody fusion surgery at Porter Adventist Hospital on November 20, 2017 without apparent complication.

499. After his surgery, Plaintiff Mr. Fish began to experience shaking, chills, fatigue, and back pain, such that he was admitted to the emergency room at Littleton Adventist Hospital on December 7, 2017 for twelve days due to sepsis.

500. The results from cultures taken from Plaintiff Fish diagnosed Plaintiff Mr. Fish with large intraabdominal sterile hematomas and a complex urinary tract infection due to Escherichia coli bacteria.

501. As a result of Plaintiff Mr. Fish's Escherichia coli bacteria urinary tract infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Fish to suffer associated economic and noneconomic damages.

50. Plaintiff Michael Gibson's surgical site infection of November 21, 2017

502. Plaintiff Michael Gibson ("Mr. Gibson") was scheduled for left total knee arthroplasty surgery and his surgeon, Dr. Todd Miner, M.D., proposed that Plaintiff Mr. Gibson undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

503. Dr. Todd Miner, M.D. performed the left total knee arthroplasty surgery at Porter Adventist Hospital on November 21, 2017 without apparent complication.

504. After his surgery, Plaintiff Mr. Gibson began to experience pain, such that Dr. Todd Miner, M.D. performed a placement of antibiotic spacers with irrigation and debridement surgery on December 19, 2017.

505. The surgery on December 19, 2017 failed and Plaintiff Mr. Gibson has undergone four knee surgeries to date due his surgical site infection.

506. The results from cultures taken from Plaintiff Gibson's surgical site diagnosed Plaintiff Mr. Gibson with a surgical site infection pathogen of Methicillin-sensitive Staphylococcus aureus, and he later developed rare Staphylococcus aureus as well.

507. As a result of Plaintiff Mr. Gibson's Methicillin-sensitive Staphylococcus aureus and rare Staphylococcus aureus infections, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Gibson to suffer associated economic and noneconomic damages.

51. Plaintiff Gordon Hall's surgical site infection of December 12, 2017

508. Plaintiff Gordon Hall ("Mr. Hall") was scheduled for C2-T1 spinal fusion surgery and his surgeon, Dr. George Frey, M.D., proposed that Plaintiff Mr. Hall undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

509. Dr. George Frey, M.D. performed the C2-T1 spinal fusion surgery at Porter Adventist Hospital on December 12, 2017 without apparent complication.

510. After his surgery, Plaintiff Mr. Hall began to experience right arm numbness, fever, and disorientation due to cord compression, such that Dr. Richard Kim, M.D. performed an incision and drainage surgery on December 24, 2017.

511. The results from cultures taken from Plaintiff Mr. Hall's surgical site diagnosed Plaintiff Mr. Hall with a surgical site infection pathogen of Methicillin-susceptible Staphylococcus epidermidis.

512. As a result of Plaintiff Mr. Hall's Methicillin-susceptible Staphylococcus epidermidis infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Hall to suffer associated economic and noneconomic damages.

52. Plaintiff Nina Tisdall Hawkins surgical site infection of December 21, 2017

513. Plaintiff Nina Tisdall Hawkins ("Ms. Tisdall Hawkins") was scheduled for a C3-T3 spinal fusion surgery and her surgeon, Dr. Sean Markey, M.D., proposed that Plaintiff Ms. Tisdall Hawkins undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

514. Dr. Sean Markey, M.D. performed the C3-T3 spinal fusion surgery at Porter Adventist Hospital on December 21, 2017 without apparent complication.

515. After her surgery, Plaintiff Ms. Tisdall Hawkins began to experience wound dehiscence and drainage from her surgical site, such that Dr. Sean Markey, M.D. performed a wound closure with debridement surgery on January 24, 2018.

516. The results from cultures taken from Plaintiff Ms. Tisdall Hawkins' surgical site diagnosed Plaintiff Ms. Tisdall Hawkins with a surgical site infection pathogen of Methicillin-sensitive Staphylococcus aureus.

517. As a result of Plaintiff Ms. Tisdall Hawkins' Methicillin-sensitive Staphylococcus aureus infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Tisdall Hawkins to suffer associated economic and noneconomic damages.

53. Plaintiff Chad Meyers' surgical site infection of December 26, 2017

518. Plaintiff Chad Meyers ("Mr. Meyers") was scheduled for subtalar joint arthrodesis and gastroc recession surgery and his surgeon, Dr. Adam Toren, M.D., proposed that Plaintiff Mr. Meyers undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

519. Dr. Adam Toren, M.D. performed the subtalar joint arthrodesis and gastroc recession surgery at Porter Adventist Hospital on December 26, 2017 without apparent complication.

520. After his surgery, Plaintiff Mr. Meyers began to experience edema and pain around his surgical site wound with wound dehiscence, such that Dr. Adam Toren, M.D. performed a debridement procedure on February 2, 2018.

521. The results from cultures taken from Plaintiff Mr. Meyers' surgical site diagnosed Plaintiff Mr. Meyers with a surgical site infection pathogen of Methicillin-susceptible Staphylococcus epidermidis.

522. As a result of Plaintiff Mr. Meyers' Methicillin-susceptible Staphylococcus epidermidis infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Meyers to suffer associated economic and noneconomic damages.

54. Plaintiff Ginny Peirce-Anstine's surgical site infection of January 5, 2018

523. Plaintiff Ginny Peirce-Anstine ("Ms. Peirce-Anstine") was scheduled for a C4-5 and C5-6 spinal fusion surgery and her surgeon, Dr. Sean Markey, M.D., proposed that Plaintiff Ms. Peirce-Anstine undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

524. Dr. Sean Markey, M.D. performed the C4-5 and C5-6 fusion spinal fusion surgery at Porter Adventist Hospital on January 5, 2018 without apparent complication.

525. After her surgery, Plaintiff Ms. Peirce-Anstine began to experience wound dehiscence and drainage from her surgical site, such that Dr. Sean Markey, M.D. performed a wound closure with incision and drainage surgery on April 4, 2018.

526. Subsequently, due to Plaintiff Ms. Peirce-Anstine's surgical site infection the spinal fusion failed, such that Dr. Sean Markey, M.D. performed a fusion revision surgery on August 22, 2018.

527. The results from cultures taken from Plaintiff Ms. Peirce-Anstine's surgical site diagnosed Plaintiff Ms. Peirce-Anstine with a surgical site infection pathogens of Methicillin-sensitive Staphylococcus aureus, rare colony of Corynebacterium, diptheroid, finegoldia magna, and actinomyces neuii.

528. As a result of Plaintiff Ms. Peirce-Anstine's Methicillin-sensitive Staphylococcus aureus, rare colony of Corynebacterium, diptheroid, finegoldia magna, and actinomyces neuii infections, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Peirce-Anstine to suffer associated economic and noneconomic damages.

55. Plaintiff Perry Skinner's surgical site infection of January 10, 2017

529. Plaintiff Perry Skinner ("Mr. Skinner") was scheduled for a thoracic fusion surgery and his surgeon, Dr. George Frey, M.D., proposed that Plaintiff Mr. Skinner undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

530. Dr. George Frey, M.D. performed the thoracic fusion surgery at Porter Adventist Hospital on January 10, 2018 without apparent complication.

531. After his surgery, Plaintiff Mr. Skinner began to experience sepsis, such that Dr. George Frey, M.D. performed a revision fusion surgery on February 27, 2018.

532. The results from cultures taken from Plaintiff Mr. Skinner's surgical site diagnosed Plaintiff Mr. Skinner with a surgical site infection with an unknown pathogen.

533. As a result of Plaintiff Mr. Skinner's unknown pathogen infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Skinner to suffer associated economic and noneconomic damages.

56. Plaintiff Ruth Schwartz's surgical site infection of January 5, 2018

534. Plaintiff Ruth Schwartz ("Ms. Schwartz") was scheduled for a C4-5 and C5-6 spinal fusion surgery and her surgeon, Dr. Edward Raczka, D.P.M., proposed that Plaintiff Ms. Schwartz undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

535. Dr. Edward Raczka, D.P.M. performed the C4-5 and C5-6 fusion spinal fusion surgery at Porter Adventist Hospital on January 5, 2018 without apparent complication.

536. After her surgery, Plaintiff Ms. Schwartz began to experience wound dehiscence and drainage from her surgical site, such that Dr. Edward Raczka, D.P.M. performed a wound closure with incision and drainage surgery on April 4, 2018.

537. Subsequently, due to Plaintiff Ms. Schwartz's surgical site infection the spinal fusion failed, such that Dr. Sean Markey, M.D. performed a fusion revision surgery on August 22, 2018.

538. The results from cultures taken from Plaintiff Ms. Schwartz's surgical site diagnosed Plaintiff Ms. Schwartz with a surgical site infection pathogens of Methicillin-sensitive Staphylococcus aureus, rare colony of Corynebacterium, diptheroid, finegoldia magna, and actinomyces neuii.

539. As a result of Plaintiff Ms. Schwartz's Methicillin-sensitive Staphylococcus aureus, rare colony of Corynebacterium, diptheroid, finegoldia magna, and actinomyces neuii infections, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Schwartz to suffer associated economic and noneconomic damages.

57. Plaintiff Charles Morganti's surgical site infection of February 20, 2018

540. Plaintiff Charles Morganti ("Mr. Morganti") was scheduled for a left total hip arthroplasty surgery and his surgeon, Dr. Todd Miner, M.D., proposed that Plaintiff Mr. Morganti undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

541. Dr. Todd Miner, M.D. performed the left total hip arthroplasty surgery at Porter Adventist Hospital on February 20, 2018 without apparent complication.

542. After his surgery, Plaintiff Mr. Morganti began to experience swelling and drainage from his surgical site wound, such that Dr. Todd Miner, M.D. performed an irrigation and debridement surgery on March 19, 2018.

543. The results from cultures taken from Plaintiff Mr. Morganti's surgical site diagnosed Plaintiff Mr. Morganti with a surgical site infection pathogens of Group B streptococcus and Methicillin-resistant Staphylococcus aureus.

544. As a result of Plaintiff Mr. Morganti's Group B streptococcus and Methicillin-resistant Staphylococcus aureus infections, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Morganti to suffer associated economic and noneconomic damages.

545. At all times relevant, Plaintiff Mr. Morganti was married to his spouse, Plaintiff Marsha Morganti.

546. Plaintiff Mr. Morganti's surgical site infection caused his spouse, Plaintiff Marsha Morganti, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

58. Plaintiff Jim Taylor's surgical site infection of March 13, 2018

547. Plaintiff Jim Taylor ("Mr. Taylor") was scheduled for a right total knee arthroplasty surgery and his surgeon, Dr. Todd Miner, M.D., proposed that Plaintiff Mr. Taylor undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

548. Dr. Todd Miner, M.D. performed the right total knee arthroplasty surgery at Porter Adventist Hospital on March 13, 2018 without apparent complication.

549. After his surgery, Plaintiff Mr. Taylor began to experience a fever and bloody drainage from his surgical site wound, such that Dr. Todd Miner, M.D. performed an arthroplasty revision with irrigation and debridement surgery on April 12, 2018.

550. Dr. Todd Miner, M.D. performed Plaintiff Mr. Taylor's arthroplasty revision with irrigation and debridement surgery on April 12, 2018 at Littleton Adventist Hospital because Porter Adventist Hospital's operating rooms were closed.

551. The results from cultures taken from Plaintiff Mr. Taylor's surgical site diagnosed Plaintiff Mr. Taylor with a surgical site infection pathogens of Pseudomonas aeruginosa.

552. As a result of Plaintiff Mr. Taylor's Pseudomonas aeruginosa infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Taylor to suffer associated economic and noneconomic damages.

553. At all times relevant, Plaintiff Mr. Taylor was married to his spouse, Plaintiff Sally Taylor.

554. Plaintiff Mr. Taylor's surgical site infection caused his spouse, Plaintiff Sally Taylor, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

59. Plaintiff Karen Wilson's surgical site infection of March 14, 2018

555. Plaintiff Karen Wilson ("Ms. Wilson") had an emergent repair of her basilic and axillary veins surgery after Parker Adventist Hospital referred her for the surgical procedure to Porter Adventist Hospital in Denver, Colorado.

556. Dr. Marcus Kret, M.D. performed the repair of her basilic and axillary veins surgery at Porter Adventist Hospital on March 14, 2018 without apparent complication.

557. After her surgery, Plaintiff Ms. Wilson began to experience pain and drainage from her surgical site, such that Dr. Marcus Kret, M.D. performed a hematoma evacuation surgery on April 30, 2018.

558. The results from cultures taken from Plaintiff Ms. Wilson's surgical site diagnosed Plaintiff Ms. Wilson with a surgical site infection of an unknown pathogen.

559. As a result of Plaintiff Ms. Wilson's unknown pathogen infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Wilson to suffer associated economic and noneconomic damages.

60. Plaintiff Mark Reinhart's surgical site infection of March 19, 2018

560. Plaintiff Mark Reinhart ("Mr. Reinhart") was scheduled for a pars plana vitrectomy surgery and his surgeon, Dr. Dennis O'Connell, D.O., proposed that Plaintiff Mr. Reinhart undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

561. Dr. Dennis O'Connell, D.O. performed the pars plana vitrectomy surgery at Porter Adventist Hospital on March 19, 2018 using sterile technique and without apparent complication.

562. After his surgery, Plaintiff Mr. Reinhart began to experience loss of vision and pain in his left eye, such that Dr. Dennis O'Connell, D.O. performed emergency surgery, including a vitreous biopsy and intravitreal injection of medications, on Plaintiff Mr. Reinhart's left eye on March 21, 2018.

563. The results from cultures taken from Plaintiff Mr. Reinhart's eye confirmed that Plaintiff Mr. Reinhart had developed a severe infection, Methicillin-resistant Staphylococcus epidermidis, deep within his eye.

564. As a result of Plaintiff Mr. Reinhart's Methicillin-resistant Staphylococcus epidermidis infection, he suffered permanent blindness in his left eye.

565. Additionally, as a result of the infection he acquired during surgery, Mr. Reinhart required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Reinhart to suffer associated economic and noneconomic damages.

566. At all times relevant, Plaintiff Mr. Reinhart was married to his spouse, Plaintiff Ilene Reinhart.

567. Plaintiff Mr. Reinhart's surgical site infection caused his spouse, Plaintiff Ilene Reinhart, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

61. Plaintiff Theresa Brazulis' surgical site infection of April 4, 2018

568. Plaintiff Theresa Brazulis ("Ms. Brazulis") was scheduled for a lumbar spinal fusion surgery and her surgeon, Dr. George Frey, D.O., proposed that Plaintiff Ms. Brazulis undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

569. Dr. George Frey, M.D. performed the lumbar spinal fusion surgery at Porter Adventist Hospital on April 4, 2018 without apparent complication.

570. After her surgery, Plaintiff Ms. Brazulis began to experience purulent drainage and bleeding from her surgical site wound and she was diagnosed with a surgical site infection.

571. Due to Plaintiff Ms. Brazulis' surgical site infection, on May 20, 2018 Plaintiff Ms. Brazulis's underwent emergency surgery at St. Mary's Hospital, which included irrigation and debridement of her surgical wound, primary closure of the wound, and a L1-2 laminectomy.

572. The results from cultures taken from Plaintiff Ms. Brazulis' surgical site diagnosed Plaintiff Ms. Brazulis with a surgical site infection pathogen of Methicillin-sensitive Staphylococcus aureus.

573. As a result of Plaintiff Ms. Brazulis's Methicillin-sensitive Staphylococcus infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Brazulis to suffer associated economic and noneconomic damages.

574. At all times relevant, Plaintiff Ms. Brazulis was married to her spouse, Plaintiff Jeffrey Brazulis.

575. Plaintiff Ms. Brazulis' surgical site infection caused her spouse, Plaintiff Jeffrey Brazulis, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

62. Plaintiff John Lovett's aborted surgery due to contaminated surgical instruments on April 2, 2018

576. Plaintiff John Charles Lovett was scheduled for a 3-level anterior lumbar fusion surgery, and his surgeon, Dr. Peter Syre, M.D. proposed that he undergo this surgery at Porter Adventist Hospital.

577. On April 2, 2018 Plaintiff Mr. Lovett presented for surgery, was taken to the operating room, was prepped and draped for surgery, and was placed under general anesthesia.

578. Plaintiff's surgeon, Dr. Peter Syre, M.D., noticed the surgical equipment was contaminated and, accordingly, Dr. Peter Syre, M.D. determined that he would not proceed with surgery.

579. Plaintiff Mr. Lovett was admitted to Porter Adventist Hospital, awaiting a date for his surgery to be completed and hospital staff noted that: "patient becomes very anxious about his surgeries. He was severely anxious the night before his last surgery."

580. Plaintiff Mr. Lovett remained admitted at Porter Adventist Hospital for two additional days, awaiting his surgery and on April 4, 2018 Plaintiff Mr. Lovett was finally able to undergo the scheduled surgical procedure.

581. As a direct and proximate result of Defendants' conduct as alleged herein, resulting in contaminated surgical instruments or equipment, Plaintiff Mr. Lovett suffered economic and noneconomic damages associated with undergoing an aborted surgical procedure, being readmitted to the hospital, awaiting a date for completion of surgery, and undergoing a second surgery knowing surgical instruments at Porter Adventist Hospital were potentially contaminated.

582. At all times relevant hereto, Plaintiff John Lovett was legally married to Plaintiff Clare Lovett.

583. Plaintiff Mr. Lovett's injuries caused his spouse, Plaintiff Clare Lovett, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

63. Plaintiff John Krasowski's aborted surgery due to contaminated surgical instruments on April 4, 2018

584. Plaintiff John Krasowski ("Mr. Krasowski") was scheduled for a multi-level laminectomy, diskectomy, and spinal fusion, and his surgeon Dr. Sean Markey, M.D., proposed that he have the surgery at Porter Adventist Hospital.

585. On April 4, 2018 Plaintiff Mr. Krazowski presented to Porter Adventist Hospital for his spine surgery where he was prepped for surgery, moved to the operating room, and placed under general anesthesia.

586. Dr. Sean Markey, M.D. began performing the surgery, opening the surgical wound from L2 to S1, where he did a subperiosteal dissection after cutting the skin and transecting the fascia with electrocautery.

587. As Dr. Sean Markey, M.D. was about to register Mr. Krasowski to the image guidance, Dr. Sean Markey, M.D. discovered a brown-yellowish, pasty material on the Stryker clamp; the contaminant was most abundant around the etched writing.

588. Further investigation by Dr. Sean Markey, M.D. yielded another clamp in the same set also had a contaminant and the surgical team also discovered evidence of water that had not been appropriately removed from the spine set.

589. Dr. Sean Markey, M.D. and the surgical team elected to tear down the entire set up, re-prep the patient, and then start with a new set up.

590. New spine sets were delivered into the OR from the Sterile Processing Department, and as Dr. Markey and the surgical team were opening these sets, they discovered yet another spinal set that had the same residue on the metal, mostly coalescing around the edged portions of the tools.

591. On April 4, 2018, Dr. Sean Markey, M.D.concluded that something in the sterilization process was not working correctly.

592. While Plaintiff Mr. Krasowski was under anesthesia in the OR, Dr. Sean Markey, M.D. consulted with administration about the contaminated instruments, and made the decision to abort Mr. Krasowski's operation, whereupon he redraped the patient with new sterile equipment, rinsed the wound and placed vancomycin powder in the surgical wound, along with a JP drain, and he closed the muscle, fascia, and skin.

593. Plaintiff Mr. Krasowski was admitted to Porter Adventist Hospital overnight.

594. On April 5, 2018 Porter Adventist Hospital closed its ORs due to a breach in sterilization of surgical instruments.

595. Plaintiff Mr. Krasowski was discharged and rescheduled for completion of his spine surgery at a different hospital.

596. As a result of the contamination of surgical instruments used in his surgery at Porter Hospital on April 4, 2018 Plaintiff Mr. Krasowski suffered economic and noneconomic damages, including medical expenses for his hospitalization and additional surgery, and pain, suffering and emotional distress associated with prolonged general anesthesia, an aborted spinal fusion surgery, transfer to a different hospital, and a second spine surgery, all due to contamination of surgical instruments used in his initial surgery at Porter Hospital.

597. As a result of the Defendants' conduct as described herein, resulting in contaminated surgical instruments, Plaintiff John Krasowski suffered economic and noneconomic damages associated with undergoing surgery with contaminated instruments, having an aborted spinal surgery, being admitted to the hospital for additional days, awaiting completion of his spine surgery, and having to undergo a second spine surgery.

598. At all times relevant hereto, Plaintiff Mr. Krasowski was legally married to his spouse, Plaintiff Cynthia L. Erickson.

599. Plaintiff Mr. Krasowski's injuries as described above caused his spouse, Plaintiff Cynthia Erickson, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

64. Plaintiff Sandra Marie Johansen's Surgical Site Infection of April 19, 2018

600. Plaintiff Sandra Marie Johansen ("Ms. Johansen") was scheduled for a left total knee arthroplasty with patella tendon repair, and her surgeon, Dr. Todd Miner, M.D., proposed that Plaintiff Ms. Johansen undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

601. Dr. Miner performed the left total knee arthroplasty and patella tendon repair at Porter Adventist Hospital on April 19, 2018 without apparent complication.

602. Within several months of her surgery, Plaintiff Ms. Johansen began to experience signs and symptoms of a Surgical Site Infection in her knee, including fever, swelling and hotness in the knee and, subsequently, she was diagnosed with a surgical site infection.

603. Due to Plaintiff Ms. Johansen's surgical site infection, on September 15, 2018 Plaintiff Ms. Johansen underwent emergency surgery, which included debridement of infected tissue and extensive irrigation, and being placed on PICC-line antibiotics

604. The results from cultures taken from Plaintiff Ms. Johansen's surgical site diagnosed Plaintiff Ms. Johansen with a surgical site infection pathogen of Group A Streptococcus.

605. Following her April 19th surgery, Plaintiff Ms. Johansen continued to have pain, swelling, and draining with necrotic tissue around her surgical site and blood work confirmed the presence of ongoing infection, such that on October 8, 2018 Ms. Johansen was diagnosed with a recurrent periprosthetic infection.

606. On October 9, 2018, Plaintiff Ms. Johansen underwent another surgery, including left knee resection arthroplasty with resection of extensor mechanism due to infection, placement of static antibiotic-impregnated cement spacer and interlocking cables with fusion of the knee.

607. As of the date of the filing of this lawsuit, Plaintiff Ms. Johansen is without a knee joint, and is scheduled to undergo an attempted left total knee revision arthroplasty.

608. As a result of Plaintiff Ms. Johansen's infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Johansen to suffer associated economic and noneconomic damages.

65. Plaintiff Lori Brown's Surgical Site Infection of April 20, 2018.

609. Plaintiff Lori Brown ("Ms. Brown") was scheduled for a bunionectomy, synovectomy with exostectomy dorsal medial lateral first metatarsophalangeal joint and her surgeon, Dr. Edward Raczka, D.P.M., proposed that Plaintiff Ms. Brown undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

610. Dr. Edward Raczka, D.P.M. performed the surgery at Porter Adventist Hospital on April 20, 2018 without apparent complication.

611. Within several weeks of her surgery, Plaintiff Ms. Brown began to experience signs and symptoms of a Surgical Site Infection in her foot and she was diagnosed with cellulitis, induration, fluctuance, edema, and effusion around the incision such that on May 18, 2018 she underwent surgical debridement followed by antibiotics.

612. On June 1, 2018, Plaintiff Ms. Brown underwent additional surgery to address osteomyelitis, which included debridement of infected tissue and bone.

613. Tissue samples taken during surgery were submitted to pathology at Porter Adventist Hospital; but were subsequently lost.

614. Plaintiff Ms. Brown was placed on PICC-line antibiotics and she underwent surgery again on July 5, 2018 for additional resection of infected bone due to chronic refractory osteomyelitis.

615. The results from cultures taken from Plaintiff Ms. Brown's surgical site ultimately confirmed infection with Coagulase-Negative Staphylococci.

616. As a result of Plaintiff Ms. Brown's infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Brown to suffer associated economic and noneconomic damages.

66. Plaintiff Don Rasberry's Surgical Site Infection of August 28, 2018

617. Plaintiff Don Rasberry ("Mr. Rasberry") was scheduled for a left total hip arthroplasty and his surgeon, Dr. Todd Miner, M.D., proposed that Plaintiff Mr. Rasberry undergo his surgical procedure at Porter Adventist Hospital in Denver, Colorado.

618. Dr. Todd Miner, M.D. performed the surgery at Porter Adventist Hospital on April 28, 2018 without apparent complication.

619. Within several weeks of his surgery, Plaintiff Mr. Rasberry began to experience signs and symptoms of a Surgical Site Infection, including swelling and fluid collection at the surgical site.

620. Plaintiff Mr. Rasberry's Surgical Site Infection was treated conservatively, but within several months Mr. Rasberry began experiencing drainage from the surgical site, such that he was diagnosed with an infected hematoma.

621. On October 18, 2018, Mr. Rasberry was admitted to Porter Adventist Hospital for infection of his hip incision and he underwent additional surgery, including incision/drainage and debridement of infected tissue.

622. The results from cultures taken from Plaintiff Mr. Rasberry's surgical site ultimately confirmed infection with Methicillin Resistant Staphylococcus Aureus and hwas treated with antibiotics, including Oritivancin followed by oral antibiotics.

623. As a result of Plaintiff Mr. Rasberry's infection, he required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Mr. Rasberry to suffer associated economic and noneconomic damages.

67. Plaintiff Janet Pettersen's Surgical Site Infection of September 17, 2018

624. Plaintiff Janet Pettersen ("Ms. Pettersen") was scheduled for a right total hip arthroplasty and her surgeon, Dr. Brian White, M.D., proposed that Plaintiff Ms. Pettersen undergo her surgical procedure at Porter Adventist Hospital in Denver, Colorado.

625. Dr. Brian White, M.D. performed the surgery at Porter Adventist Hospital on September 17, 2018 using sterile technique and without apparent complication.

626. Within three weeks after her September 17, 2018 right hip surgery, Plaintiff Ms. Pettersen began to develop a fever and swelling in her right hip and thigh.

627. On October 6, 2018, Plaintiff Ms. Pettersen went to the emergency department at Penrose St. Francis due to a loss of range in motion in her right hip, fever, and redness and swelling at the surgical site.

628. Subsequently, Plaintiff Ms. Pettersen was transported to Porter Adventist Hospital via ambulance.

629. On October 8, 2018, Dr. Brian White, M.D. performed surgery on Plaintiff Ms. Pettersen's right hip which included an irrigation and debridement, as well as placement of antibiotic beads.

630. A culture performed on the fluid in Plaintiff Ms. Pettersen's surgical wound diagnosed a Methicillin-sensitive Staphylococcus aureus infection in her right hip surgical site.

631. As a result of Plaintiff Ms. Pettersen's infection, she required additional hospitalizations for medical complications, surgery and other procedures, and antibiotics, as well as caused Plaintiff Ms. Pettersen to suffer associated economic and noneconomic damages.

632. At all times relevant, Plaintiff Ms. Pettersen was married to her spouse, Plaintiff Eric Pettersen.

633. Plaintiff Ms. Pettersen's surgical site infection caused her spouse, Plaintiff Eric Pettersen, to suffer derivative economic and noneconomic damages associated with a loss of spousal consortium.

The Conditions at Porter Adventist Hospital During Plaintiffs' Surgeries

634. In performing the surgeries at Porter Adventist Hospital, each and every Plaintiffs' surgeons and their surgical teams followed standard hospital infection prevention protocol for each and every surgery, including hand hygiene practices, respiratory hygiene practices, urinary

catheter infection prevention practices, general surgical infection prevention practices, and surgical site infection prevention practices.

635. Unbeknownst to the surgical teams for the Plaintiffs' surgeries, one or more of the instruments used during each and every surgery of the Plaintiffs at Porter Adventist Hospital which resulted in surgical site or blood-borne pathogen infections were contaminated and had not been properly sterilized due to the above-described systemic failures of the SPD at Porter Adventist Hospital.

636. At the time of Plaintiffs' surgeries, Defendant Porter knew or should have known that the SPD was systemically failing to comply with hospital protocol and industry standards for sterilizing surgical instruments.

637. At the time of Plaintiffs' surgeries, Defendant Porter knew or should have known that the SPD's failure to properly sterilize instruments created an increased and undue risk of infection to surgical patients, including Plaintiffs.

638. Each and every one of Plaintiffs' infections related to surgeries at Porter Adventist Hospital and subsequent medical treatment were directly and proximately caused by contaminated surgical instruments used in their surgeries at Porter Hospital, resulting from Defendant Porter's failure to properly sterilize the surgical instruments used during their surgeries occurring on dates ranging between 2015 and 2018.

639. But for Defendant Porter's tortious conduct described herein, Plaintiffs would not have had surgery at Porter Adventist Hospital, would not have undergone surgery with instruments that were improperly sterilized, would not have been exposed to undue risk of surgical site infection, and would not have developed an infection and suffered damages as described herein.

Plaintiffs', the Surgeons', and the Public's Reliance on Porter Adventist Hospital's Public Misrepresentations Regarding Sterilization

640. None of the Plaintiffs' initial surgeries as described in more detail herein were "emergency" in nature, but rather, were elective such that each Plaintiff chose and agreed to having surgery at Porter Adventist Hospital, with the exception of Plaintiff Karen Wilson.

641. All Plaintiffs, with the exception of Plaintiff Karen Wilson, either selected Porter Adventist Hospital or was recommended by their surgeon to undergo their surgical procedure at Porter Adventist Hospital in Denver, Colorado.

642. Plaintiff Karen Wilson was directed to undergo her surgery at Porter Adventist Hospital by the doctors, staff and/or management of Parker Adventist Hospital.

643. At all relevant times, Defendant Porter represented and held itself out to the consumer public, to licensing and regulatory entities, to patients, and to medical staff as a licensed and accredited surgical facility that was properly staffed, equipped and operated in a manner that could

safely provide aseptic surgical services to operative patients, including Plaintiffs and their surgeons, including by maintaining surgical asepsis through sterile technique and proper sterilization of surgical instruments and equipment.

644. At all relevant times, Defendant Porter represented and held out to patients and medical staff, including Plaintiffs and their surgeons, that surgical instruments processed by and utilized in surgeries at Defendant Porter were fit for use and did not present an undue risk of infection for patients.

645. Plaintiffs, their surgeons, and the general public had a right to rely upon, and did rely upon, Defendant Porter's representations to the consumer public, to licensing and regulatory entities, to patients, and to medical staff that Porter Adventist Hospital provided safe and aseptic surgical services, including surgical instruments and equipment that were properly and safely sterilized.

646. Unbeknownst to Plaintiffs or their surgeons, and as set forth in further detail below, the representations made by Defendant Porter as described above were false, misleading, and/or deceptive.

Plaintiffs Remained Unaware That Their Severe Infections Were Caused by Ongoing Sterilization Problems at Porter Adventist Hospital

647. After recovering from their infections, not a single Plaintiff was ever informed by Porter Adventist Hospital or any provider that their infection had been caused by negligent conduct or by contaminated surgical instruments.

648. From the date of their surgery through April 4, 2018 each and every Plaintiff remained unaware that their infections had been caused by Defendant Porter's negligent conduct.

649. From the date of their surgery through April 4, 2018, each and every Plaintiff did not know, and could not have discovered with reasonable diligence, that their infections had been caused by Defendant Porter's negligent conduct.

Plaintiffs' Discovery of Their Injuries and Their Legal Causes

650. On April 4, 2018, Defendant Porter began notifying patients who had orthopedic or spine surgery at Defendant Porter between July 21, 2016 and April 5, 2018 that they were exposed to an elevated risk of bacterial SSIs and blood borne pathogens such as HIV, hepatitis C, and hepatitis B.

651. Despite having already prepared letters to mail to thousands of patients, Defendant Porter did not notify Plaintiffs John Krasowski, John Lovett, and Teresa Brazulis prior to their surgeries on April 4, 2018 of the letter or that there were known, ongoing problems with sterilization of surgical instruments at Porter Adventist Hospital.

652. Sometime on or after April 4, 2018, news media sources began to report about the sterilization breaches at Porter Adventist Hospital.

653. All Plaintiffs learned of the sterilization breaches at Porter Adventist Hospital on April 4, 2018 or sometime after via receipt of the notification letter from Defendant Porter, a media source, or a third party alerting them to the information about the sterilization breaches from news media sources.

654. Sometime after April 5, 2018 Plaintiffs learned from news media, and/or a third-party relaying information from news media sources, that all operating rooms at Porter Adventist Hospital had closed due to breaches in the process of sterilizing surgical instruments.

655. Sometime after April 5, 2018 Plaintiffs learned from news media, and/or a third-party relaying information from news media sources, that any patients potentially exposed to blood-borne pathogens would receive a letter via mail instructing them to undergo blood testing to confirm whether they had contracted any blood-borne pathogens due to sterilization protocol breaches.

656. Sometime after April 5, 2018 Plaintiffs discovered for the first time that their infections developed after their surgeries at Porter Adventist Hospital had been caused by Defendant Porter's negligent conduct as described herein.

657. Plaintiffs did not know before April 5, 2018 and could not have discovered with reasonable diligence before April 5, 2018, that their infections were caused by Defendant Porter's negligence as described herein.

658. Plaintiffs have all filed this lawsuit within two years of the date that a reasonable person in their position could know, in the exercise of reasonable diligence, that they had been injured by the tortious conduct of Defendant Porter.

V. FIRST CLAIM FOR RELIEF

(Corporate Negligence)

659. Plaintiffs incorporate all preceding paragraphs by reference.

660. At all relevant times, Defendant Porter owed Plaintiffs a duty to exercise that degree of care expected of reasonable hospital corporations under the same or similar circumstances.

661. Additionally, Defendant Porter stood in a special relationship with its patients, including Plaintiffs, such that Defendant Porter owed Plaintiffs a duty of reasonable care premised on that special relationship.

662. Defendant Porter's duty to its patients, including Plaintiffs, included but was not limited to an affirmative duty to warn of any risks or dangerous conditions that it was either aware of or of which it should have been reasonably aware.

663. These risks and dangers included, but were not limited to, known contamination problems within Porter Adventist Hospital, known failures to properly clean and sterilize surgical instruments, unsterile surgical equipment, understaffed sterilization departments, and unsafe

sterilization procedures and post-operative infections occurring in conjunction with improper sterilization.

664. At all relevant times, Defendant Porter breached its duty and was negligent by:

a. Failing to adequately establish and enforce facility policies and procedures

b. Failing to ensure the timely and appropriate selection, development, implementation, direction, coordination, and enforcement of hospital systems and policies to ensure the reasonable and adequate sterilization of surgical equipment on the date of Plaintiffs' surgeries;

c. Failing to adequately staff the SPD for the volume and complexity of scheduled surgical cases;

d. Failing to ensure adequate pre-cleaning of instruments before they left the OR;

e. Hiring SPD staff without ensuring that they had the required certifications;

f. Failing to ensure that SPD staff were properly trained and capable of completing their duties;

g. Failing to monitor and supervise SPD staff to ensure competence;

h. Failing to properly train/discipline/retrain SPD staff who had repeated contamination errors;

i. Failing to ensure sterile surgical tools were available at the start of surgical cases;

j. Failing to audit surgical trays which left the SPD;

k. Failing to monitor contamination events in the SPD and surgical trays;

l. Failing to act upon sterilization issues or concerns once they were identified;

m. Failing to ensure vendors wore surgical scrubs over personal clothing in restricted areas;

n. Failing to reasonably and adequately respond to reported instances of unsterile surgical equipment;

o. Failing to reasonably and adequately respond to reported instances of unsafe practices in the SPD;

p. Failing to reasonably and adequately respond to reported instances of the SPD being improperly staffed both in number and qualifications of the staff;

q. Failing to provide reasonable and adequate training regarding the reporting of any unsterile instruments;

r. Failing to provide reasonable and adequate training regarding the reporting of any unsafe or unsterile practices;

s. Failing to provide reasonable and adequate training regarding the reporting of any unsafe or unsterile conditions;

t. Failing to have the necessary sterilization policies and protocols in place;

u. Failing to take the appropriate steps to address and correct complaints, reports, and concerns regarding the process of sterilizing surgical instruments,

v. Failing to reasonably and adequately monitor and enforce the sterilization policies and protocols;

w. Failing to ensure that the instrument washers were properly maintained;

x. Allowing patients, including Plaintiffs, to undergo an operation in an environment which Defendant Porter knew or should have known was unsafe, unsterile and unregulated such that the health and safety of patients was predictably at risk for suffering infection and serious life-threatening consequences as a result;

y. Failing to ensure that SSIs were adequately tracked, investigated, and reported; and,

z. Failing to encourage staff to report sterilization concerns and problems to the proper managerial, oversight, licensing, and regulatory personnel and/or entities.

665. As a direct and proximate result of the negligence of Defendant Porter as described herein, Plaintiffs have suffered and will continue to suffer injuries, damages and losses including but not limited to medical costs and expenses, lost wages, loss of household services, and other economic losses and damages, as well as noneconomic losses and damages including but not limited to mental anguish, pain and suffering, inconvenience, impairment of the quality of life, and emotional stress, as well as Plaintiffs' Spouses have suffered a loss of spousal consortium.

VI. SECOND CLAIM FOR RELIEF

(Violation of the Colorado Consumer Protection Act)

666. Plaintiffs incorporate all preceding paragraphs by reference.

667. At all relevant times, the provisions of the Colorado Consumer Protection Act ("CCPA"), C.R.S. § 6-1-101, et seq., were in effect.

668. At all relevant times, the CCPA protected the public as actual or potential consumers in situations where consumers do not have and cannot reasonably gain access to truthful information relevant to a contemplated transaction unless it comes from the persons or entities offering the services or goods.

669. The services and goods provided by the Defendant to Plaintiff constitute services and goods within the meaning of C.R.S. § 6-1-113(1)(a).

670. Upon information and belief, in the course of Defendant Porter's business, Defendant Porter markets and advertises to potential customers throughout the state of Colorado through various forms of advertising media, including but not limited to internet advertisements, billboards, and print signage.

671. Marketing and advertising hospital services and performing medical procedures are matters of public interest and concern for the State of Colorado.

672. At all relevant times, Defendant Porter made false, deceptive, and/or misleading representations and statements concerning the nature and quality of their hospital services in these advertising and marketing materials, as described elsewhere herein.

673. At all relevant times, Defendant Porter knew or should have known that such representations were false or, alternatively, Defendant Porter acted negligently and/or recklessly with respect to the truth or falsity of such statements.

674. Upon information and belief, the false, deceptive, and/or misleading representations of Defendant Porter in this regard actually reached hundreds or thousands of consumers across Colorado and across the country.

675. Defendant Porter's false, deceptive, and/or misleading representations occurred in the course of Defendant Porter's business as a hospital.

676. Over 6,000 patients who received surgeries at Defendant Porter between January 1, 2015 and April of 2018 were affected by Porter's false and misleading statements and omissions, and induced into having surgery at Porter Adventist Hospital by Porter's false and misleading statements and omissions.

677. Upon information and belief, Defendant Porter made such false, deceptive, and/or misleading representations with actual knowledge that they were false, deceptive, and/or misleading.

678. Upon information and belief, Defendant Porter knowingly and intentionally made such false, deceptive, and/or misleading representations in order to take advantage of the relative lack of sophistication and knowledge of actual and potential consumers concerning matters relevant to the services and goods advertised and marketed by the Defendant.

679. At all relevant times, the misrepresentations of Defendant Porter had the capacity or tendency to deceive Plaintiff and other potential and actual patients seeking orthopedic surgery and related goods and services.

680. At all relevant times, Plaintiffs were actual consumers of Defendant Porter's services.

681. Upon information and belief, at all relevant times, the deceptive trade practices of Defendant Porter had the potential to significantly impact consumers and did in fact impact actual consumers as described elsewhere herein.

682. Defendant Porter engaged in deceptive trade practices in the course of their business, vocation, and occupation by making false statements of fact, knowingly and/or recklessly and willfully without regard to their consequences, with the intent to deceive and mislead Plaintiffs, which induced Plaintiffs and/or their surgeons to act and/or to refrain from acting and which had the capacity to deceive.

683. The deceptive practices Defendant Porter engaged in include but are not limited to:

a. Representing that Defendant Porter's services were of a particular quality and standard when they knew or should have known that they were of another, in violation of C.R.S. § 6-1-105(1)(g);

b. Falsely representing and advertising the benefits of surgery at Defendant Porter, in violation of C.R.S. § 6-1-105(1)(e).

684. Upon information and belief, Defendant Porter made the following representations, or words to the same effect, in their advertisements to the public at large on their website regarding the quality and value of their services:

a. "We consistently deliver exceptional care and strive for excellence in all we do."

b. "We are called to uphold the highest standards, with integrity driving every decision we make and every action we take."

c. "Our leading-edge teams deliver remarkable care, high-quality outcomes and unparalleled patient satisfaction among a wide variety of medical specialties, services and programs to help you get well and stay well."

d. "As the region's leading health care provider, Centura Health is firmly committed to quality and patient safety."

e. "As the region's leading health care provider, we are committed to clinical excellence and superior outcomes."

f. "Defendant Porter Adventist Hospital is dedicated to providing innovative, quality treatment for orthopedic conditions."

g. “At Porter Adventist Hospital, patient safety and clinical quality is always our top priority and our single most important job.”

h. “We uphold and enforce the highest medical standards, the most rigorous clinical requirements, and we maintain an unwavering commitment to patient safety.”

i. “[O]ur dedicated orthopedic operating rooms are among the most sophisticated, sterile and state-of-the-art surgical suites...”

685. The same or similar statements above were present on Defendant Porter’s website and/or promotional materials from January 2015 through the present.

686. At the time these and similar statements were made, Defendant Porter knew or should have known that they were false or misleading in that Defendant Porter Adventist Hospital had ongoing problems with sterilization and infection control which was known to hospital staff and leadership.

687. Plaintiffs’ surgeons actually and reasonably relied upon these and similar statements in selecting a hospital perform Plaintiffs’ surgical procedures.

688. Upon information and belief, Defendant Porter had dozens of unique daily viewers on its website between January 2015 through present.

689. Defendant Porter was aware of the true facts concerning the actual benefits and risks of surgery at Defendant Porter at the time the advertisements were made to the public.

690. The deceptive practices alleged herein had the capacity or tendency to deceive potential and actual patients seeking surgical services.

691. Defendant Porter’s advertisements were directed to the market generally, in the form of widespread advertisement to and deception of actual and prospective consumers of surgical services.

692. Because of Defendant Porter’s advertising, as well as representations made to potential patients, the public, as actual or potential customers of Defendant Porter’s services, is significantly impacted.

693. Upon information and belief, the number of consumers affected by Defendant Porter’s deceptive trade practices is sufficiently large.

694. Defendant Porter, as a provider of surgical services and as a surgical facility, possessed greater sophistication and bargaining power than actual and potential consumers of Defendant Porter’s services, who had no way to independently evaluate the quality, standards, and benefits of Defendant Porter’s services, or to verify Defendant Porter’s claims.

695. Upon information and belief, Defendant Porter advertises a network of over 900 physicians and over 1400 associates.

696. Plaintiffs had no specialized knowledge of or way to independently evaluate the quality, standards, and benefits of surgery at Defendant Porter as compared to other surgical facilities.

697. Plaintiffs were actual consumers of Defendant Porter's services.

698. The services provided by Defendant Porter to Plaintiffs constitute services within the meaning of C.R.S. § 6-1-113(1)(a).

699. Defendant Porter's failure to provide the quality medical care advertised as set forth above caused actual harm to Plaintiffs.

700. Thousands of patients, including Plaintiffs, were harmed by Defendant Porter's false and misleading statements that induced said patients into having surgery and surgeons to perform surgeries at Porter Adventist Hospital.

701. As a direct and proximate result of Defendant Porter's violation of the CCPA, Plaintiffs have suffered and will continue to suffer injuries, damages and losses including but not limited to medical costs and expenses, lost wages, loss of household services, and other economic losses and damages, as well as noneconomic losses and damages including but not limited to mental anguish, pain and suffering, inconvenience, impairment of the quality of life, and emotional stress, as well as Plaintiffs' spouses have suffered a loss of spousal consortium.

702. Defendant Porter engaged in bad faith conduct within the meaning of C.R.S. § 6-1-113(2.3), entitling Plaintiffs to an award of treble damages, attorney's fees and costs pursuant to C.R.S. § 6-1-113(2)(III).

VII. THIRD CLAIM FOR RELIEF

(**Negligence Per Se – Federal CMS Regulations**)

703. Plaintiffs incorporate all preceding paragraphs by reference.

704. At all relevant times, the Secretary of Health and Human Services was empowered under 42 U.S.C. § 1302 to make and publish such rules and regulations as necessary for the efficient administration of the Secretary's function in administering Medicare and Medicaid.

705. At all relevant times, the Secretary of Health and Human Services, through CMS, promulgated various rules and regulations as conditions of participation in Medicare and/or Medicaid.

706. At all relevant times, certain of the regulations duly promulgated by CMS were in effect, had the force of law, and were applicable to facilities such as Porter Adventist.

707. For example, at all relevant times, Defendant Porter had a legal duty to maintain an effective governing body that is legally responsible for the conduct of the hospital and ensures that

services provided at the hospital, like the cleaning of surgical instruments, are provided in a safe manner and in accordance with professional standards under 42 CFR 482.12.

708. Likewise, at all relevant times, Defendant Porter had a legal duty to develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program under 42 CFR 482.21.

709. Likewise, at all relevant times, Defendant Porter had a legal duty to provide a sanitary environment to avoid sources and transmission of infections and communicable diseases under 42 CFR 482.42.

710. Likewise, at all relevant times, Defendant Porter had a legal duty to provide surgical services that were well-organized and provided in accordance with acceptable standards of practice under 42 CFR 482.51.

711. Likewise, at all relevant times, Defendant Porter had a legal duty to abide by the requirements of 42 C.F.R. Part 482, Subparts A, B, C, D, and E.

712. At all relevant times, such regulations were promulgated and enforced in order to protect the safety of the public, including patients like the Plaintiffs named above, at facilities like Porter Adventist.

713. At all relevant times Defendant Porter breached their legal duties under such federal regulations and were negligent as described elsewhere herein.

714. Plaintiffs are members of the class of persons which the aforementioned statutes were intended to protect.

715. The purpose of the aforementioned statutes was to protect against the type of injuries or losses that Plaintiffs and Plaintiffs' Spouses sustained.

716. As a direct and proximate result of the negligence *per se* of Defendant Porter as described herein, Plaintiffs have suffered and will continue to suffer injuries, damages and losses including but not limited to medical costs and expenses, lost wages, loss of household services, and other economic losses and damages, as well as noneconomic losses and damages including but not limited to mental anguish, pain and suffering, inconvenience, impairment of the quality of life, and emotional stress, as well as Plaintiffs' Spouses have suffered a loss of spousal consortium.

VIII. FOURTH CLAIM FOR RELIEF

(Negligence Per Se – Colorado Hospital Regulations)

717. Plaintiffs incorporate all preceding paragraphs by reference.

718. At all relevant times, the provisions of 6 CCR 1011-1 Chapters II and IV were in effect.

719. At all relevant times, Defendant Porter had a legal duty to establish a quality management program appropriate to the size and type of facility pursuant to 6 CCR 1011-1, Chapter II, General Licensing Standards, Part 3 – Quality Management, § 3.1.

720. Likewise, at all relevant times, Defendant Porter had a legal duty to assign sufficient supporting personnel to central medical-surgical supply services and to properly train those personnel in central medical-surgical supply services pursuant to 6 CCR 1011-1, Chapter IV, General Hospitals, Part 5 – Facility Operations, § 5.101(3).

721. Likewise, at all relevant times, Defendant Porter had a legal duty to maintain continuous supervision throughout receiving, cleaning, processing, sterilizing, and storing surgical instruments pursuant to 6 CCR 1011-1, Chapter IV, General Hospitals, Part 5 – Facility Operations, § 5.102(1).

722. Likewise, at all relevant times, Defendant Porter had a legal duty to maintain a governing board responsible for all functions performed within the hospital pursuant to 6 CCR 1011-1, Chapter IV, General Hospitals, Part 6 – Governance and Leadership, § 6.102(2).

723. Likewise, at all relevant times, Defendant Porter had a legal duty to have an infection control program responsible for reducing the risk of acquiring and transmitting nosocomial infections and infectious diseases in the facility pursuant to 6 CCR 1011-1, Chapter IV, General Hospitals, Part 9 – Infection Control Services, § 9.101(1).

724. At all relevant times, these and similar provisions of 6 CCR 1011-1 Chapters II and IV were promulgated and enforced in order to protect the safety of the public, including patients like the named Plaintiffs at facilities like Porter Adventist Hospital.

725. At all relevant times, Defendant Porter breached their legal duties under such state regulations and were negligent as described elsewhere herein.

726. Plaintiffs are members of the class of persons which the aforementioned statutes were intended to protect.

727. The purpose of the aforementioned statutes was to protect against the type of injuries or losses that Plaintiffs and Plaintiffs' spouses sustained.

728. As a direct and proximate result of the negligence *per se* of Defendant Porter as described herein, Plaintiffs have suffered and will continue to suffer injuries, damages and losses including but not limited to medical costs and expenses, lost wages, loss of household services, and other economic losses and damages, as well as noneconomic losses and damages including but not limited to mental anguish, pain and suffering, inconvenience, impairment of the quality of life, and emotional stress, as well as Plaintiffs' Spouses have suffered a loss of spousal consortium.

IX. FIFTH CLAIM FOR RELIEF

(Extreme and Outrageous Conduct)

729. Plaintiffs incorporate all preceding paragraphs by reference.

730. With respect to the conduct alleged in this Complaint, Defendant Porter engaged in or was responsible for conduct so outrageous in character, and so extreme in degree, that knowledge of all the relevant facts would cause the outrage and resentment of any reasonable member of the community against Defendant and would, in fact, shock any reasonable member of the community.

731. Specifically, Defendant Porter and its employees and/or agents engaged in extreme and outrageous conduct by, among other things:

a. Failing to adequately clean and sterilize surgical instruments in the SPD;

b. Failing to monitor contamination events;

c. Failing to act upon sterilization issues once they were identified;

d. Ignoring and not properly responding to risks and incidences of infection which were either known or should have been known;

e. Resorting to continuous use of IUSS instead of correcting deficiencies in the standard sterilization process; and,

f. Failing to adequately track, investigate, and report SSIs.

732. Upon information and belief, Defendant Porter engaged in such extreme and outrageous conduct either knowingly, intentionally, or recklessly.

733. As a direct and proximate result of the extreme and outrageous conduct of Defendant Porter as described herein, Plaintiffs have suffered and will continue to suffer injuries, damages and losses including but not limited to medical costs and expenses, lost wages, loss of household services, and other economic losses and damages, as well as noneconomic losses and damages including but not limited to mental anguish, pain and suffering, inconvenience, impairment of the quality of life, and emotional stress, as well as Plaintiffs' Spouses have suffered a loss of spousal consortium.

X. SIXTH CLAIM FOR RELIEF

(Misrepresentation/Concealment/Nondisclosure)

734. Plaintiffs incorporate all preceding paragraphs by reference.

735. At all relevant times, it was part of the business of Defendant Porter to give information upon which the safety of recipients of that information depended, including but not limited to Plaintiffs.

736. At all relevant times, in the course of their business, Defendant Porter negligently and/or intentionally made false, misleading, and/or deceptive representations of material fact to Plaintiffs

and/or Plaintiffs' surgeons in order to facilitate their selection of Defendant Porter for their surgical procedures, including but not limited to the following:

a. "We consistently deliver exceptional care and strive for excellence in all we do."

b. "We are called to uphold the highest standards, with integrity driving every decision we make and every action we take."

c. "Our leading-edge teams deliver remarkable care, high-quality outcomes and unparalleled patient satisfaction among a wide variety of medical specialties, services and programs to help you get well and stay well."

d. "As the region's leading health care provider, Centura Health is firmly committed to quality and patient safety."

e. "As the region's leading health care provider, we are committed to clinical excellence and superior outcomes."

f. "Porter Adventist Hospital is dedicated to providing innovative, quality treatment for orthopedic conditions."

g. "At Porter Adventist Hospital, patient safety and clinical quality is always our top priority and our single most important job."

h. "We uphold and enforce the highest medical standards, the most rigorous clinical requirements, and we maintain an unwavering commitment to patient safety."

737. Upon information and belief, the same or similar statements above were present on Defendant Porter's website and/or promotional materials from January 2015 through present.

738. At the time these and similar statements were made, Defendant Porter knew or should have known that they were false.

739. Defendant Porter concealed and/or failed to disclose facts about its inadequate sterilization practices and surgical site infection rate to its surgical patients, including Plaintiffs and their surgeons.

740. Plaintiffs and/or their surgeons actually and reasonably relied upon these and similar statements in selecting a hospital to undergo and/or perform their surgical procedure at Defendant Porter.

741. Plaintiffs consented to their surgeries relying on the assumption that the concealed and/or undisclosed facts did not exist or were different from what they actually were.

742. Defendant Porter continued to negligently conceal and/or misrepresent known problems with its inadequate sterilization processes after Plaintiffs' surgical procedure.

743. At the time these and similar statements were made by Defendant Porter, Plaintiffs and their surgeons had no way of knowing or investigating the truth or falsity of these representations.

744. Defendant Porter made these and similar statements with the intent that potential patients such as Plaintiffs would rely on them in choosing a surgical facility.

745. Defendant Porter made these and similar statements with the intent that potential or current surgeons would rely on them in choosing a surgical facility to request or maintain their surgical privileges and conduct surgeries.

746. Plaintiffs and their surgeons justifiably relied on Defendant Porter's representations.

747. As a direct and proximate result of the conduct of Defendant Porter as described herein, Plaintiffs have suffered and will continue to suffer injuries, damages and losses including but not limited to medical costs and expenses, lost wages, loss of household services, and other economic losses and damages, as well as noneconomic losses and damages including but not limited to mental anguish, pain and suffering, inconvenience, impairment of the quality of life, and emotional stress, as well as Plaintiffs' Spouses have suffered a loss of spousal consortium.

XI. SEVENTH CLAIM FOR RELIEF

(Joint & Several Liability Pursuant to C.R.S. 13-21-111.5(4))

748. Plaintiffs incorporate by reference all preceding paragraphs of this Complaint as if fully set forth herein.

749. From early-2015 through 2018, Defendant Porter Adventist Hospital, Defendant Porter Adventist Health System, and Defendant Centura Health Corporation consciously worked together, collaborated, and conspired—and deliberately pursued a common plan or design—to increase corporate profits without regard for the likelihood of increasing infections at Porter Adventist Hospital.

750. This common plan, design or scheme agreed upon and pursued jointly by the Defendants included, but was not limited to:

a. reducing staff in the sterilization unit and other hospital units responsible for infection control;

b. encouraging and scheduling more surgeries than could be safely and reasonably managed given the resources and operations at Porter Adventist Hospital;

c. failing to properly hire, train, or supervise hospital staff or outside personnel responsible for surgical instrument sterilization;

d. failing to implement and enforce hospital policies, procedures and protocols pertaining to infection control and surgical instrument sterilization;

e. knowingly allowing hospital staff or outside personnel to violate hospital policies pertaining to infection control and sterilization;

f. knowingly failing to investigate or respond to reports of contaminated surgical instruments;

g. knowingly failing to implement changes to improve infection control processes;

h. knowingly failing to comply with state and federal laws, rules or regulations regarding reporting of infections;

i. knowingly concealing from state and federal authorities a known and persistent problem with surgical instrument sterilization and resulting infections; and,

j. knowingly underreporting infections in violation of state and federal laws, rules and regulations.

751. The common plan, design or scheme was agreed upon and pursued jointly by the defendants for the purpose of maximizing or increasing corporate profits.

752. Defendants shared a mutual understanding and agreement as to their common plan or design to maximize or increase corporate profits.

753. Defendants expressly or impliedly agreed to work with each other to accomplish the above-stated common plan or design at Porter Adventist Hospital for at least a three-year period spanning from 2015-2018.

754. As a direct result of Defendants' common design, plan or scheme, surgical instruments used in patient surgeries at Porter Adventist Hospital were routinely not properly cleaned or sterilized, and routinely contained visible and microscopic bioburden, and routinely and regularly caused infections in surgical patients, including but not limited to Plaintiffs.

755. Accordingly, Defendants are jointly and severally liable for damages to Plaintiffs and Plaintiffs' Spouses, pursuant to C.R.S. § 13-21-111.5(4).

XII. DAMAGES PURSUANT TO C.R.S. § 13-21-201, et seq. FOR PLAINTIFF BETTY WRISTON
(Wrongful Death)

756. As a result of the acts and/or omissions by the defendants as set forth above, Thomas Wriston suffered a severe infection that caused his death.

757. As a result of the acts and/or omissions by the defendants as set forth above, Plaintiff Betty Wriston has been caused to suffer damages, including but not limited to loss of her husband's companionship, economic loss including loss of future earnings and financial support, and grief, sorrow and emotional loss relating to the death of their family members.

758. Additionally, as a result of the acts and/or omissions by the defendants as set forth above, the Estate of Thomas Wriston has been caused to suffer damages, including medical expenses associated with Thomas Wriston's severe infection, illness, treatment, and death.

XIII. DAMAGES

759. As a direct and proximate result of the tortious conduct of Defendants as described herein, Plaintiffs have suffered in the past, and will continue to suffer in the future, economic and noneconomic damages, including but not limited to: medical and other expenses associated with medical injury, lost wages, loss of household services, pain, suffering, permanent impairment/disfigurement, and loss of quality of life.

760. As a direct and proximate result of the tortious conduct of Defendants as described herein, Plaintiffs' Spouses have suffered in the past, and will continue to suffer in the future, loss of spousal consortium.

WHEREFORE, Plaintiffs and Plaintiffs' Spouses pray for judgment against the Defendants and for compensatory damages in an amount to be determined by the trier of fact, pre-judgment interest, post-judgment interest, trebled damages, attorney's fees and costs pursuant to C.R.S. § 6-1-113(2)(III), costs, and attorney fees, and for such other and further relief as this Court may deem appropriate.

PLAINTIFFS REQUEST A JURY OF SIX TO HEAR ALL ISSUES IN THIS CASE.

DATED: June 14, 2019

Respectfully submitted,

WAHLBERG, WOODRUFF, NIMMO & SLOANE, LLP

/s/ David S. Woodruff
David S. Woodruff, #32585
Megan K. Matthews, #43998

In accordance with C.R.C.P. 121 §1-26(9) a printed copy of this document with signatures is being maintained by the filing party and will be made available for inspection by other parties or the Court upon request.

Plaintiffs' and Plaintiffs' Spouses Addresses:

Kevin Alley, 17158 E. Whitaker Drive, Unit E, Aurora, CO 80015

Jacqueline and Joseph Armstrong, 7988 Larkspur Circle, Frederick, CO 80530

Nicholas and Deborah Bakarich, 1173 W. Fork Way, Watkins, CO 80137

Scott and Beauvais, 6245 Northwoods Glenn Drive, Parker, CO 80134

Theresa and Jeffrey Brazilus, 279 Gary Drive, Grand Junction, CO 81503

Lori Brown, 470 Circle Drive, Denver, CO 80206

Rebecca Brown, 5476 Suffolk Circle, Castle Rock, CO 80104

Carmelita Carrillo, 6810 Cory Place, Colorado Springs, CO 80915

Sarah Cline-Lebsack and David Lebsack, 2442 Carr Street, Lakewood, CO 80214

Jonathan Colbeth, 14310 Grant Street #3-105, Thornton, CO 80623

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